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ORIGINAL ARTICLES.

DIPHTHERIA: ETIOLOGY, DIAGNOSIS, PROPHYLAXIS.¹

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THE bacillus discovered by Klebs, afterward studied by Loeffler, is all but unanimously accepted by those who are considered authorities and by physicians in general as the real etiologic factor in the production of diphtheria. Not infrequently an article may be noticed from the pen of a talented man² who claims that the Klebs-Loeffler bacillus is not the cause of diphtheria because it is not found in every case of the disease, is found in healthy throats, and does not produce the typical disease when inoculated into animals, and, indeed, that the modern doctrine of bacteriology is a gigantic mistake.

There are, it is true, a few cases which present the clinical features of diphtheria in which the Klebs-Loeffler bacillus is not found, but could we eliminate the personal equation, make our technic absolutely perfect, and be assured that the bacilli if present in very small numbers on the false membrane would invariably be secured by the process of swabbing, it is undoubtedly true that the germs would be found in every case of the disease.

The objection against its acceptance, that the diphtheria bacillus is found in healthy throats, is not sound. Even the rigid scientific postulates of Koch do not insist upon such a condition. The Loeffler bacillus when injected subcutaneously into animals does not produce typical diphtheria, but does cause pseudo membranes to appear on mucous surfaces. Then again, injection into animals causes paralysis, which in character, localization, and time of occurrence are very like those seen in man.

The most conclusive evidence, however, of the action of the diphtheria bacillus upon susceptible animals is furnished by the personal experience of McFarland.³ To quote from the account given in his text book: "All possible skepticism of the specificity of the bacillus on my part was dispelled by an accidental infection which kept me housed

for three weeks during the busiest season of the year. Without having been exposed to any known diphtheria contagion, while experimenting in the laboratory, a living virulent culture of the diphtheria bacillus was drawn into a pipette and accidentally entered my mouth. Through carelessness no precautions were taken to prevent serious consequences, and as a result of the accident two days later my throat was full of typical pseudo membrane, which private and health-board bacteriological examinations showed contained pure cultures of the Klebs-Loeffler bacilli."

The experiment thus inadvertently inaugurated and carried forward by McFarland furnishes a very conclusive proof of the third rule of Koch in regard to the germ under consideration. It will be remembered that this prescribes that a given organism, when injected into a susceptible animal, must produce the disease.

The notion prevalent in some quarters that sewer-gas is a means of inducing the disease is evidently not based upon scientific truth. Bacteria do not rise from moist surfaces, hence this factor as a source of infection must be disregarded. Another statement by Smith⁴ is that diphtheria has been on the increase in spite of the fact that systems of sewerage, in England especially, have been greatly improved.

The dairy, when cared for by persons sick with diphtheria, or by those who harbor the germs in their throats, has been proved to be an important focus for the distribution of the disease. This is well illustrated by cases noted by Howard⁵ at Ashtabula, Ohio.

The crowding which is occasioned by life in tenements seems to favor the continuance, as well as the dissemination of the disease.

London shows a marked decrease in the number of cases during the summer or vacation months.⁶ This is also true of other cities; therefore the congregation of children in schools is undoubtedly responsible in a measure for the spread of the disease.

The conclusion to which bacteriologists and clinicians have been forced in regard to the diagnosis of diphtheria is that the presence or absence of the

¹ Read at the Meeting of the Ohio State Pediatric Society, held at Springfield, Ohio, May 9 and 10, 1899.

² Bantock, *Brit. Med. Journ.*, April 8, 1899.

³ McFarland, "Text-book upon Pathogenic Bacteria," second edition, p. 294.

⁴ *Lancet*, October 16, 1897.

⁵ W. F. Howard, Jr., *Amer. Jour. Med. Sciences*, December, 1897.

⁶ J. C. Thrush, *Brit. Med. Journ.*, August 22, 1896.

Klebs-Loeffler bacillus must be ascertained before an intelligent opinion can be formed as to the nature of the disease.

That the character of the membrane is not a safe guide to a diagnosis is insisted upon by Vierordt,¹ and many others, who have found typical lacunar anginas with the presence of the Loeffler bacillus. These cases often lapse into typical diphtheria, hence the great importance of a bacteriologic examination early in the course of the disease.

The choice of a culture medium for the rapid and accurate diagnosis of diphtheria has been much discussed by bacteriologists. Loeffler's blood-serum mixture is in most general use at the present time. With the aid of this medium one is able to make a diagnosis within twelve hours. The method proposed by Ohlmacher, the examination microscopically of the still invisible growth after five hours in the incubator, seems to be quite reliable. During the past year in the Laboratory of the Department of Health of Columbus, forty six cases were examined at the end of five hours, and again at the end of twelve hours. In every instance at the end of twelve hours I found the diagnosis identical with that obtained after five-hours' growth.

Loeffler's blood-serum mixture, in addition to furnishing food for development of the diphtheria bacillus, supplies a nutritious soil for the growth of the staphylococcus and the streptococcus. The latter species sometimes interferes with a proper diagnosis of the case. To eliminate this possible error and to secure a uniform medium, Joos² makes use of a serum-agar, upon which the Loeffler bacillus thrives, the streptococcus will not grow, while the staphylococcus shows a meager growth. Upon this medium small colonies of the Loeffler bacillus may be seen after four- or five-hours' growth at body temperature. Colonies of ten to twelve-hours' growth are fully developed, and are much larger than those grown upon the Loeffler mixture. Joos has examined more than 100 cases, both by Loeffler's method and his own. The conclusion is that his method is simpler, equally accurate, and more rapid. If these results are corroborated by other investigators there is no doubt that this newest medium is well-nigh perfect. The medium proposed by Joos is as follows: 300 c.c. of ordinary blood serum; 50 c.c. of normal sodium solution; 150 c.c. of distilled water or bouillon. This is placed in a flask, heated in a water-bath for two or three hours at 60° to 70° C., and the flask is then placed in a steam sterilizer for from half to three-quarters of an hour; 500 c.c.

of pepton bouillon and 20 grams of agar, which is dissolved as rapidly as possible, are then added. When the solution is perfect it is at once filtered, hot, and sterilized for a quarter of an hour in the autoclav at 100° to 110° C., after which it is poured into Petri dishes.

Prophylaxis.—The most notable point in a consideration of prophylaxis in diphtheria is that while proper measures have been utilized in the disinfection of apartments and clothing the disease is on the increase. The explanation of this inconsistency is undoubtedly in the well established truth that convalescents and persons associated with diphtheria patients become carriers in their throats of virulent diphtheria bacilli. Healthy persons are then infected by association with these diphtheria carriers, as they may be called.

Certain practises in schools conduce to the spread of the bacilli from the throats of the apparently immune to those who are susceptible. Among others may be mentioned the use of slates or lead-pencils from a common stock, which necessitates the interchange of these articles from day to day. The common drinking-cup is also a frequent disseminator of the disease. Müller¹ investigated the throats of 92 children in the Charité Hospital at Berlin. The Klebs-Loeffler bacillus was found present in 20 children having no changes in the throat. Six showed the presence of the germs upon entrance to the hospital, while 14 were infected after admission. The spread of the bacilli from bed to bed could readily be observed. One patient had virulent bacilli in the throat for two and one-half months. Animal experimentation proved the virulence of the bacteria in twelve cases. Aaser² found that disinfection of a barracks occupied by a diphtheria patient and sterilization of clothing by steam at 110° C. did not check the spread of the disease. An investigation of the throats of the 89 men in the barracks, with the discovery that 17 contained virulent Loeffler bacilli, furnished a clue to the progress of the disease. These 17 suspects were isolated. One developed classical diphtheria, 2 lacunar angina, others remained well, except for a reddened condition of the fauces which persisted as long as the bacilli were found.

The experiences of the authorities just cited, as also of others, lead them to the belief that all persons who harbor Klebs-Loeffler bacilli in their fauces should be isolated. In one healthy child no method of treatment proved sufficiently potent to remove the bacilli from the throat, whereupon the isolation continued nine months.

¹ *Berliner Klin. Woch.*, November 8, 1897.

² "Untersuchungen über Diphtheriediagnose," *Centralbl. f. Bakter.*, Band xxv, No. 8-10, March, 1899.

¹ "Vahrbuch f. Kinderheilkunde," Bd. xliii, Heft 1.

² *Deutsch. Med. Woch.*, No. 22, 1895.

The solution of this moot question would seem to be in the discovery of some treatment which would be effective in the elimination of this fatal disease producer. Until such knowledge is at hand there can be no doubt that our duty as practitioners is to isolate persons with Klebs-Loeffler bacilli when such a procedure is practicable.

The proof that diphtheria is at times communicated to susceptible persons by those in whose throats Loeffler bacilli are present led me to an investigation of the throats of a number of general practitioners as to the presence of the Klebs-Loeffler bacillus. The appended table, embodying the results of these experiments, shows that of a total of 11 throats of healthy physicians examined, 2 showed virulent Klebs-Loeffler bacilli, two yielded pseudo-diphtheria bacilli, and 7 gave no significant growth:

Doctor.	Cases of Diphtheria or Tonsillitis in Practice at Time of Examination.	Result of Examination of Throat.
1.	No cases for three weeks.	No Klebs-Loeffler bacilli.
2.	Two cases of pharyngitis.	Pseudo-diphtheria bacilli.
3.	Two cases of tonsillitis.	No Klebs-Loeffler bacilli.
4.	Dismissed a case of diphtheria ten days before.	Klebs-Loeffler bacilli in pure culture. Luxuriant growth. Guinea-pig inoculated with culture showed a grayish membrane, necrosis and edema.
5.	One case of diphtheria.	Klebs-Loeffler bacilli present showing a slight growth. The bipolar stain well marked.
6.	Two cases of sore throat.	No growth.
7.	Several cases of pharyngitis.	Showed a streptothrix.
8.	No cases of throat disease for several weeks.	Sarcina.
9.	No cases recently.	No growth.
10.	One case of syphilitic sore throat; one case of tonsillitis.	Staphylococcus pyogenes aureus.
11.	No cases for several weeks.	Pseudo-diphtheria bacilli present.

stain was easily produced in these cells; the bacilli were of the long and slender variety, hence did not bear a resemblance to the pseudo-bacillus. In mingling the culture with water, the material did not, as is true with the pseudo-bacillus, mix readily, but showed persistent little granules. This was probably the true bacillus capable of inducing the disease when in a favorable throat.

The result of this work is not without interest, in that there is in it unquestionably a partial explanation of the spread of diphtheria. The work of Flügge has shown that the minute droplets of saliva produced in conversation and thrown out in the act of phonation carry with them any bacteria which may be present in the throat. There is sufficient ground to conclude that physicians in this manner become unconscious aids in disseminating the disease.

In the light of the foregoing statements, there are certain precautions which should be observed in an effort to restrict diphtheria: First, the bacteriologic examination of every patient with a sore throat, not only for the sake of the patient, but also in the interest of others, who, when infected, may have a more serious form of the disease. Second, the isolation, when practicable, and an attempt at the removal of diphtheria bacilli in every case of convalescents and others harboring the germs in their throats. Third, a watchful care should be exercised by physicians to avoid contamination from diphtheria patients, and efforts should be made to free their throats of germs when present.

SUGGESTIONS CONCERNING EARLY DIAGNOSIS IN PULMONARY TUBERCULOSIS.¹

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Few subjects in recent years have attracted greater interest in the profession than the general problem of pulmonary tuberculosis. With a view to the ultimate lessening of the disease, medical attention has been directed to the advocacy of its prevention, restriction, and control through governmental authority and provision. More exact knowledge concerning its contagiousness has been promulgated among the laity by the dissemination of educational literature. Concerning certain special methods of treatment much has been written by enthusiastic, and occasionally conscientious, observers. Greater recognition is being given to the general conservative measures of management, the adaptability of

¹ Read at the sixteenth annual meeting of the American Climatological Association, held at New York, May 9, 10, and 11, 1899.

various climates to the different stages of the disease, and a greater appreciation accorded the beneficent influence in the community of carefully conducted sanatoria. Yet the unfortunate fact remains that thousands of lives are being sacrificed annually on account of mistaken or delayed diagnosis. It is now generally accepted that consumption is a curable disease, in the sense of its permanent arrest; that the earlier the diagnosis, the better the prognosis; and that only in early cases are genuinely satisfactory results obtained. The time is coming when the profession will not accept the somewhat vague reports of observers concerning various degrees of improvement secured from climatic change, serum-therapy, or general management. Rather will it demand more definite statements as to permanent results, with special reference to total arrest, shown by the well-substantiated absence of rational symptoms and physical signs. Such will be the basis in the increasing multiplicity of reports upon which authentic conclusions will eventually be based. Recorded results of such a satisfactory nature will never be rendered save in those cases in which the diagnosis is made early and the cases come under trained observation in their incipiency. Generally speaking, it has not been such a class of cases that I have been privileged to observe in Colorado, where the advanced case is the rule and not the exception.

Early diagnosis, then, assumes a position in the general consideration of pulmonary tuberculosis of vastly more practical importance than climatic change, general management, or prophylaxis. It is true that perfect accuracy of diagnosis may be established by the recognition of the tubercle bacillus, but not always before the destructive process has already considerably advanced, the constitutional disturbance pronounced, or even the development of secondary infection. I have not infrequently failed for a considerable period to discover the bacilli in the sputum in cases in which the physical signs furnished indubitable evidence of a recent and not inactive tuberculosis. In other cases the significance of the symptoms and signs has been incontrovertible before the appearance of expectoration. Due recognition is given to the diagnostic value of the tuberculin reaction. Recent investigations with the Röntgen-rays disclose their utility for diagnostic purposes in thoracic disease. Neither of these, however, by reason of the necessary restrictions upon their employment are ordinarily within the immediate reach of the general practitioner. The claim has been made for the diagnosis of the so-called pre-tubercular state from the morphology of the blood, but it has thus far lacked satisfactory confirmation. In view of the frequent obvious difficulties for the

clinician in establishing an exact and early diagnosis through the agency of the microscope, the Röntgen-rays, and the tuberculin of Koch, is it not profitable at this time to review the well-known and perhaps old-fashioned principles of diagnosis with the aid of the stethoscope and thermometer, the careful and painstaking application of which are too frequently overlooked? The distressing results of error and delay have not been occasioned by inability to apply the newer diagnostic principles, but on account of the failure to adequately appreciate the significance of rational symptoms, to recognize accurately the physical signs, and to properly interpret their import. In the majority of instances the available data for diagnosis has been amply sufficient to warrant its provisional establishment and demand for suitable advice as to the mode of life and residence long before the medical attendant has awakened to a realization of his responsibility.

As illustrative of this I will refer briefly to observations made from my own experience. In reviewing my recorded cases of pulmonary tuberculosis I have selected therefrom a series of 546 seen in private practice and continued under observation for a considerable period in Colorado, although the disease was contracted elsewhere. Three hundred and eighty-eight, or 71 per cent., of the subjects arrived in the State with distinct evidences of tubercular infection in each lung. With reference to the duration of the disease before arrival, my statistics, computed from a conscientious inquiry concerning the time of onset of definite symptoms characteristic of the disease, are as follows: Less than 3 months thereafter, 36; 3 to 6 months, 65; 6 to 9 months, 67; 9 to 12 months, 70; 12 to 18 months, 83; more than 18 months, 225; total, 546. The total average period of delay in 546 cases is a little more than 18 months, affording abundant opportunity for advanced pulmonary and constitutional impairment. The average loss of weight from the normal at time of arrival is 19 pounds. Sixty-four and one half per cent. of the patients presented marked constitutional disturbance, as evidenced by a considerable rise of temperature, feeble and rapid pulse, distressing cough with abundant expectoration, impaired appetite, and a correspondingly greater loss of weight. Nearly 62 per cent. of this class did not seek climatic change until after one year had elapsed following the development of the disease, and 80 per cent. until after 6 months. One hundred and five, or 19.2 per cent., had well-defined cavities, nearly all of these exhibiting pronounced rational symptoms of constitutional disturbance, with rather more than the average loss of weight and an average duration before arrival of 20½ months. Two hundred and

seventy, or 47.6 per cent., presented a family history of strong inherited susceptibility to tuberculosis.

Concerning the method of onset, 83, or 15.2 per cent., upon careful investigation may be safely considered to trace the origin of the disease to a distinct attack of influenza. The average duration of the disease in this class before arrival was a little more than 12 months, much shorter than the period for the total number, while the average loss of weight was 21.9 pounds. It is perhaps interesting to note, somewhat irrelevantly, that the number of such cases has materially diminished during the past few years, the proportion in the first 200 cases—from 1892 to 1895, inclusive—being 19 per cent.; during 1896 and 1897, 18 per cent.; and for the 200 cases in 1898, being but little more than 9 per cent.

One hundred and twenty-nine patients, or more than 21 per cent. stated the onset to be of a definite bronchitic character with an average duration of 15 months and 24 days following the inception of a severe cold. The average loss of weight was 17.1 pounds. One hundred and fifty-nine, or 29 per cent., described it to be of a gradual anemic onset with an average period before arrival of nearly 2 years. The loss of weight was 17 pounds. One hundred and fourteen, or 20.2 per cent., presented the history of a sudden hemorrhage as the first symptom distinctly referable to the disease. Of this class the average loss of weight was 17.6 pounds, and the average duration before arrival was 2 years, 3½ months, much longer than the average of the total number. Exclusive of those with definitely hemorrhagic onset, 134 had suffered from one or more hemorrhages in the subsequent course of the disease before arrival. Sixty-one are unclassified with reference to the method of development, a very considerable number of these following measles, typhoid, and pleurisy. Singularly, an equal number, 61, are found to have experienced a distinct idiopathic pleurisy either preceding the apparent origin of the pulmonary process, occurring as an initial manifestation, or developing subsequently. In 14 of these an effusion had been recognized. The average period following the pleurisy before arrival was 36 months.

Is not the character of the cases sent to Colorado a striking commentary on the necessity of a more thorough appreciation of the principles capable of everyday application, upon which to base early diagnosis? One of the significant features of the analysis is the relatively shorter period before arrival, especially in those cases beginning with influenza, and to a less extent in those with bronchitic origin, as compared with the longer duration of those

with anemic, and more particularly hemorrhagic onset. It would seem to be apparent from this, (1) that cases beginning with an acute attack of influenza pursue a more rapid course, according in general earlier diagnosis and demanding more prompt climatic change; (2) that the occurrence of a hemorrhage does not convey to the mind of the medical attendant, as would naturally be supposed, its full and startling import as a diagnostic feature.

It is not my purpose to attempt a wearisome recapitulation of the rational symptoms and physical signs of pulmonary tuberculosis so familiar to us all. I am impressed, however, from a constant and more or less intimate association with pulmonary invalids that there are a few factors of recognized importance which are frequently ignored by the busy practitioner.

As regards the rational signs, the non-appreciation of the significance of morning cough, even without expectoration, persistent daily rise of temperature, loss of weight, and other well-known evidences of constitutional impairment would indeed appear inexcusable. But how often do we find denial or absence of cough, periods of normal temperature, and even recent increase of weight in the presence of fairly definite physical signs in the same way that we may fail to detect satisfactory physical evidences of the disease, despite rather pronounced subjective symptoms? It is apparent that the presence or absence of no single rational sign can be safely accepted as a factor of paramount diagnostic value. The grouping of certain clinical manifestations, without other satisfactory cause, should lead to strong suspicions of a concealed focus of tuberculosis despite immediate absence of physical signs. It must be added, however, that in the majority of instances the signs are present and recognizable once a thorough examination of the chest is made.

As preliminary to a detailed consideration of the rational signs on the part of the medical adviser there should be instituted a careful inquiry as to the extent of inherited susceptibility, the history of the individual with reference to the previous existence of idiopathic pleurisy with or without effusion, an apparently trivial or remote pulmonary hemorrhage, the occurrence of grip, a succession of colds, a protracted convalescence from typhoid or malaria, the history of a slowly resolving pneumonia, a recent severe attack of whooping-cough or measles, and others of etiologic importance. The development of indefinite symptoms following a history of any of these conditions should be regarded with grave suspicion. The initial occurrence of hemorrhage without readily assignable cause should furnish even in the absence of all clinical manifestations or physical

signs a strong, suggestive indication of the existence of an already active though limited focus of tubercular infection. Further, a pulmonary hemorrhage supervening in the course of other rational symptoms without physical evidences, should afford convincing testimony concerning the actual nature of the existing pulmonary process. The occasional dry but persistent unexplained cough, even unassociated with other rational symptoms should offer at least a clear indication for continued medical observation and repeated examinations. While the absence of an elevation of temperature constitutes no argument for the exclusion of the diagnosis of a tubercular deposit, its presence under certain conditions is assuredly an element of exceeding value. The characteristics of temperature of more especial significance and which can only be appreciated by repeated use of the thermometer at two or three-hour intervals in suspected cases, during a period of several weeks, are its regularity and atypical course, an average for the day slightly above normal, its usual though not invariable rise in the evening, and absence of corresponding systemic disturbance.

The thorough and painstaking examination of the chest immediately upon the development of suspicious symptoms, and its frequent repetition, if necessary, will usually suffice through the detailed application of the principles of auscultation and percussion in establishing for clinical purposes a sufficiently early diagnosis. As a matter of fact, such an examination is seldom made until a provisional diagnosis has become apparent from the rational symptoms, and the consultant at once recognizes physical evidences of advanced infection. Is it not, then, of practical importance, prefatory to a consideration of the more recent aids to the recognition of consumption, to continue to emphasize a more strict and conscientious adherence to the principles of physical diagnosis, now ignored in so many instances? Apropos of this I would especially condemn:

1. Delay in instituting any physical examination whatever until long after the development of pronounced constitutional and pulmonary impairment.

2. Failure to examine upon the bare skin, the presence of clothing effectually preventing any approach to accurate results.

3. Neglect to examine the entire chest, the bases, interscapular spaces, and axillary regions being frequently overlooked.

I would deplore particularly the existence of:

1. Erroneous conceptions concerning the significance of the absence of percussion-dulness at the apices, an active process often being capable of recognition by auscultation considerably before the evidence of consolidation are apparent.

2. The non-recognition, in the absence of râles, of the various modifications in disease of the normal respiratory sounds.

3. Inaccurate interpretation of localized diminished intensity of auscultatory sounds, elevation of pitch, harshness of quality and prolongation of expiration.

I would severely criticize:

1. Failure to utilize cough preceding forced inspiration in eliciting the presence of slight moisture in the finer tubes.

2. The non-appreciation of the almost pathognomonic significance of a circumscribed bronchiolitis, even in the absence of dulness or other auscultatory signs.

SOME SURGICAL ASPECTS OF SYPHILIS.¹

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(Concluded from page 397)

In the Joints.—It is a peculiar fact that though all other manifestations of syphilis are well studied the joint lesions seem to be much overlooked. The surgeon probably comes in contact with these cases more frequently than the syphigrapher, and much of the advance in this work has been due to the surgeons. It is scarcely possible to think that the acute and multiple synovitis occurring during the primary eruption and with slight fever can be mistaken by any one for acute rheumatism, yet such has been the case. The acuteness of the onset, the multiplicity of the joint inflammation suggest an infectious disease, the exact course of which should be found if suspected. The joint inflammations following the exanthemata, the multiple epiphyseal osteomyelites, gonorrhœa and large intra-articular hematoma, are not infrequently thus confounded with syphilis and *vice versa*. The difficulty in ascribing the true cause is more frequently due to imperfect history on the part of the patient and neglect on the part of the surgeon than it is to an actual difficulty in finding the cause. A differential diagnosis between this type of syphilis and the gonorrhœal can only be thought of in the rarer cases of gonorrhœal synovitis which are multiple and have the character of the swollen synovitis and peri-articular edema. In the pure gonorrhœal synovitis without a mixed infection the synovitis is not attended by formation of pus and an edema in the surrounding tissues does not exist. Large intra articular hematoma, owing to the absorption of the serum of the blood, give rise to fever and multiple joint inflammation, but other-

¹ Read at a Stated Meeting of the New York Academy of Medicine, held March 16, 1899, in a discussion on syphilis.

wise to no symptoms. So also in many of the exanthemata multiple lesions may occur within the joints which give no other symptoms than those of swelling, very slight edema, and some slight fever. The subacute or chronic serous synovites occurring during the later stages of the acquired variety are histologically at first serous synovites and later become papillary synovites with at times defects in the cartilages of the joints. They occur generally without injury, are more or less painful and the fluid in the joint is generally abundant. Ankylosis is not present, but fremitus is induced within the joint due to the papillary synovitis and the defects in the cartilage. This variety requires to be distinguished from the tubercular hydrops, monarticular arthritis deformans and monarticular chronic rheumatic arthritis. In the former cases the subacute course as compared with the chronic, the want of local symptoms in tuberculosis as against syphilitic joints, the presence of the fluid in syphilis, as against the variability of fluid in the hydrops of tuberculosis, and the history and a careful examination will always allow one to arrive at a distinct diagnosis. In the monarticular arthritis deformans injury to the joint is a most distinctive symptom. The injury produces a compression fracture of the heads of the bones, and is frequently seen in the ankle and knee from injury received by falling from great heights and landing upon the feet. The deformities in the articular plates, the deformities in the joint itself, and the foreign bodies present are sufficient when they exist to class the case as one of monarticular arthritis deformans. In the monarticular rheumatic arthritis the want of hydrops and a tendency to ankylosis are characteristic symptoms. The main striking point, however, in all these cases is the rapid response to antisyphilitic treatment, while the disease itself withstands all other kinds of treatment. In an uncertain case this is the very best diagnostic means.

The third variety is one in which a gumma situated beyond the synovial membrane in the tissues of the capsule by extension to the joint gives rise to a serous or papillary synovitis. If the gumma extends into the joint a gummatus synovitis or arthritis is induced. This variety is comparatively easy of diagnosis since the presence of the gumma, of the ulcers, or the scars from other adjacent gummata without other manifestations of syphilis being present are generally sufficient to lead one to the diagnosis of a secondary joint involvement.

The fourth variety of acquired syphilis is a gradual involvement of the joint, secondary to a periostitis, or an osteomyelitis, and running the same course as the preceding variety. Its diagnosis usu-

ally depends upon the diagnosis of the bone lesion.

It often happens in the acquired variety that the diagnosis is dependent upon the previous or present manifestations of the disease and the multiplicity of the joint lesion, but one may be obliged to work without any of these aids, other than the joint lesion. It is especially so in the hereditary variety of syphilis and too much importance cannot be given to it, owing to the imperfect results obtained in the treatment of tubercular joints in children, and to the fact that many syphilitic joints are considered tubercular. We should not increase this number by including the syphilitic joints and we should select from the other the syphilitic joint diseases, for no disease does better under appropriate treatment.

These are more common than is generally supposed, thirty-seven per cent. of children having keratitis in hereditary syphilis have joint disease; eighty-eight per cent. occur in the knee-joint, and fifty-nine per cent. of them are double, existing upon both sides. Histologically, we have in the first variety a primary serous synovitis with or without cartilage defects. In the second, third, and fourth varieties we have a serous papillary or a gummatus synovitis. In the second, due to a periarticular gummata; in the third to a periostitis and osteomyelitis; and in the fourth to an osteochondritis with or without perforation into the joint or separation of the epiphysis.

The first variety, the serosynovitis with or without cartilage defects, is generally double and in the knee joints. These subacute cases are quickly suspected even though no manifestation of syphilis is present. Such a case I remember in a child of four years of age, otherwise healthy, with a double gonitis, subacute in character and but slightly painful. There was some local heat, but no contracture in the joint nor redness over the joint. At the time of observation the disease had been present twenty-one days at the least. Inunction of mercury and internal administration of the iodid of potash brought about a successful result within two weeks. This case I knew to be syphilitic, for the mother had been treated in the hospital for the same disease, and it was present at the time of the presentation of the child, and she was examined and found to have a well-marked syphilitic gumma of the cheek.

When the latter three varieties occur in late childhood, they may be easily mistaken for white swelling when they have reached the gummatus period. In the earlier stages when the exudation into the joint is serous or the synovial membrane is papillary and a peri-articular gumma, a periostitis, an osteomyelitis or an osteochondritis is present the distinction even when the joint lesion is unilateral is much

easier. Bilateral involvement in the knee, elbow, and ankle joints are especially suspicious. These joints are, moreover, characterized by greater mobility and a more pronounced pain and swelling of the ends of the bones, than exist in tuberculosis. In comparison with the acute articular or the gonorrhoeal rheumatism syphilis shows a decided absence of pain in rest and a more pronounced swelling. It must not be forgotten that in hereditary syphilis pains exist within the joints without observable reaction (an arthralgia). These pains resemble growing pains, and are often so classed, or are considered rheumatic. No hereditary lesion exists and the cause is not explained.

Bones.—Both in the acquired and in the hereditary variety of syphilis, the bones are primarily affected and it is probable that we meet the hereditary varieties mostly between the ages of five and ten years; they may, however, occur as late as the twenty-eighth year.

It is not with the more frequent varieties of bone syphilis, *i.e.*, gummatous periostitis or osteomyelitis that the surgeon finds his difficulty, for here multiplicity of the lesions, the part of the bone involved and its mode of involvement are generally sufficient, even when other manifestations are not present, to distinguish the process as being syphilitic. It is, however, in the first place with the exostosis, the hyperostosis and the osteophytes, especially in the hereditary syphilis, that the surgeon has to do, since their pressure upon the muscles, nerves, and organs may lead to severe symptoms which, when the disease is distinctly understood, may be easily relieved.

Particularly interesting are the three cases of exostosis occurring during the first week of extra-uterine life reported by Labré. The first case was one of asymmetrical exostoses upon the upper epiphyseal line of both femora. The autopsy showed syphilitic disease on the epiphyseal line. In the second case an exostosis existed upon the lower end of the humerus which disappeared under the use of blue ointment and iodid of potash. In the other case an exostosis upon the trochanter major suddenly disappeared with the disappearance of a periostitis of the ulna under blue ointment and the iodid of potash. Labré therefore concludes that a certain number of exostoses are syphilitic, and the diagnosis depends upon the age of the child at which the exostosis of syphilis takes place, as well to the fact that the treatment under blue ointment and iodid is curative. Fournier has lately described a case of exostosis of hereditary syphilis causing a most painful contracture of the forearm, which exostosis was discovered by means of the Roentgen-rays and was cured under proper treatment. He also describes a case of acquired syphilis in a man

of sixty years, whose primary lesion was obtained two and a half years previous and which was followed by severe amyotrophic joint affections: multiple exostoses upon the metatarsus, tibia, fibula, radius, and frontal bone. These exostoses diminished under proper treatment. Again, the hyperostoses of syphilis are responsible for deformities in the articulations adjoining the disease, and for this reason care should be taken to observe them. Such deformities as are seen particularly in the ankle joint, where from tubular hyperostoses pes valgus may result.

The rapidly developing gummata of the skull and long bones are not infrequently confounded with tuberculosis or sarcoma. In making such a distinction in the skull or in the long bones, it is to be remembered that the osteomyelitis of syphilis is usually gummatous, and that the periostitis is usually a sclerosing process, and that in the acquired disease the diaphysis is involved. In the hereditary and early acquired syphilis the epiphyses are involved. This holds good in the long bones, whereas in the flat bones the process is more frequently a gummatous than a sclerosing one. In the differentiation of these three almost similar processes syphilis of the bone is characterized by its painfulness and its exquisitely chronic course. In the acute osteomyelitis, we have the location in the bone, the acute beginning and the high fever, the intoxication and the early development of pus. In the sarcoma its location near the epiphysis, its more rapid growth, its early involvement of the skin and its larger mass. In tuberculosis the location in the bone, the slight pain and the very chronic course, its cold abscess, and the large sinuses resulting are characteristic.

We find many mistakes made in diagnosis and some in the removal of syphilitic gumma for neoplasms. Such a mistake has occurred to Langenbeck in the case of a man, twenty-five years of age, who denied all previous syphilis. He was sent to Langenbeck with a diagnosis of lipoma of the shoulder. The tumor developed after a blow five months previous to Langenbeck's seeing him. This tumor had increased with severe pain and existed on the posterior surface of the right scapula. It was a sharply defined tumor; it followed the movements of the scapula and was not attached to the skin. The surface of the tumor seemed lobular. The skin over the surface had an ulcer with undermined edges and a base formed of necrotic fascia. Suspecting that the tumor was not a sloughing lipoma, but syphilis under the appropriate treatment he effected a cure.

It is probable that the subject reported as being

operated upon by Carl Reyher of St. Petersburg, in Langenbeck's *Archives* of 1897, vol. xxxvii, had a gumma of the shoulder. He removed a tumor from the shoulder of a man, fifty-three years of age, the microscopic diagnosis of which was fibrosarcoma. Within three months a local return took place in the scar. On the elbow and shoulder and deltoid muscle old syphilitic scars were found. The tumor involved both the acromial end of the scapula near the acromioclavicular joint and the clavicle. The humerus was not involved. The diagnosis was sarcoma and syphilis. The shoulder was removed, together with the arm, by Von Bergmann according to Berger's method. The patient recovered and returned to his work and after two years' time died. The autopsy showed the existence of visceral syphilis, and it is very probable that the shoulder was removed for a gumma instead of a sarcoma.

Again, so eminent a surgeon as Kuster has removed a gumma of the sternum for a sarcoma, and the error was justifiable since the iodid of potash did not act so promptly as is usually the case.

Such a case I had myself at the New York Hospital some three years ago. The man was admitted having had a portion of the sternum removed for sarcoma involving the upper third of the sternum and the sternoclavicular articulations. The man was sent to the hospital with a diagnosis of a return of the sarcoma. Careful examination of his history as well as the character of the local disease in the sternum soon convinced one of the possibility of syphilis. Proper treatment cured.

With the rarer variety of syphilitic involvement of the spine consisting (1) in ex-ot-hyperostosis in the cervical, dorsal, and lumbar regions, which may induce pressure upon the cord or the nerves and give rise to symptoms; (2) in an osteomyelitis with necrosis, which is a very rare condition. As a rule this osteomyelitis of the spine is tubercular or both syphilitic and tubercular.

With the development of gummata in bone fractures may occur from very slight injuries. In the acquired varieties these fractures occur usually in the diaphyses, whereas in the hereditary variety they consist in the separation of the epiphysis from the diaphysis induced by a gummatus osteochondritis in the first years of life and give rise to a condition known as Parrot's pseudo-paralysis.

In the Rectum.—Syphilis is frequently located and has been not infrequently removed under the head of cancer. Carcinoma, which exhibits an irregular, hard, and nodular growth with deep, gaping ulcerations upon the hard and indurated rectal wall, can be easily mistaken for chronic inflammation and

ulcers, and these two for syphilitic stricture and ulcers or an anorectal syphiloma.

Rectal disease may be subjected to the microscope and if only small-celled infiltrations are present and granulation tissue, one naturally thinks of syphilis although the history and examination of the whole body reveals nothing. This negative diagnosis, however, is of little value unless we substantiate it by other general symptoms or by a characteristically diseased rectum.

Were we able to see the cases early diagnosis would often be an easy matter, but this is not the case and we cannot see the most characteristic manifestations in the rectum, *viz.*: the small gummata of the mucous membrane. It is characteristic of syphilis of the rectum to have the ring-like strictures close above the internal sphincter, above which, according to the age of the process, we find ulcerations, circular, with clearly cut indurated edges, not undermined, existing singly or occurring in groups, or we find above this stricture gummata globular, elastic, cellular deposits situated in the submucous tissue and existing singly or in multiple form. These gummata not infrequently undergo fatty degeneration and are replaced by a fibrous mass, which not infrequently when several exist is mistaken for carcinoma. Again, syphilis of the rectum may exist under the form of anorectal syphiloma of Fournier, which process as you are aware consists in a fibrous hyperplasia of the mucous membrane without ulcers unless it be secondary to it. This leads to a stricture which extends rarely higher than $2\frac{1}{2}$ inches from the anus. Sooner or later either in the hereditary or in the acquired variety of syphilis the rectal wall above the stricture is studded with papillomata or adenomata. The microscope here may show nothing for or against syphilis even when it exists. Macroscopically above the stricture and the papillomata the ulcers and the gummata along the extreme edge of the advancing syphilis alone afford us the diagnostic evidence of syphilis. Microscopically the most evident lesions are obtained above the stricture and the ulcerated gummata. Here the mucous membrane is completely transformed into a granulation tissue composed in part of leucocytes and in part of epithelioid cells with large spaces between them (blood spaces without walls). In the submucous tissue gummata are found which consist of granulation tissue, perivascular and endovascular, similar to that found in angiosarcoma. So also in the gummata which present themselves as nodules, the formation from vessels is the same, so that in both cases the cells in the tissue stand in close relation to the walls of the vessels. Of the greatest diagnostic value, therefore, is the hard, bluish-red no-

dule in the mucous membrane which consists of this network of capillaries and small veins, the walls of which are in a state of proliferation producing epithelioid spindle and round cells. Following this disease in the mucous membrane the submucous and the intermuscular gummata appear, and owing to the necrobiosis of their tissue lead to the serpiginous ulceration when superficial, and when deep to strictures and contracture.

With reference to a distinction between syphilis and many other affections which simulate it, it appears to me to be useless to arrange in columns as in our text-books the striking differential points, for it is not where these differences can be recognized that our errors exist, but rather in the cases where this fails and where we are to judge largely from a few facts which render the diagnosis probable rather than certain. In this category of suspected and doubtful cases are placed those in whom (either child or adult) the manifestations of a recent or remote infection exist (acquired), or the evidence of a family taint is well founded (hereditary). Equally suspicious are the so-called tumors of muscle, since syphilitoma of muscle is more frequently met than other tumors in this tissue. In Esmarch's experience it amounted to more than one-half of all primary tumors in the muscular system. We must class as doubtful all cases appearing to be sarcomata, recurring rapidly after removal (Paget's rapidly recurring fibroids). Many of the cases so classed have been proven to be syphilitic and have been cured by antisypilitic treatment, although the pathologic examination has been that of a angiobroma. Just such a case came under my observation in 1898. The patient was sent to me by Dr. J. P. McGowan of this city for the correction of a deformity in the upper lip the result of contracture during the dissolution of a gumma by internal treatment. The gumma had been an extensive one, and the connective tissue remaining had formed a mass the size of the thumb. The skin over the mass was not involved. It was adherent to the superior maxilla, and was to the touch hard and easily circumscribed. It had remained in this condition for two months, and at the time seemed to be stationary. This mass was removed, the deformity was corrected by a slight plastic operation, and the patient kept under internal medication. Pathologic diagnosis: Fibrosarcoma. This diagnosis could not be believed in since the evidence of former syphilis was present, nor have we up to the present time any reason for changing our diagnosis of a fibroid degeneration of a syphilitoma of the muscles of the lip.

Another class of suspicious cases are those which have been cured by erysipelas; in both lupus and

the severe syphilides the toxins of erysipelas apparently act antagonistically and render nil their respective toxins. It is indeed probable that the cures obtained in the treatment of sarcomata by the injection of the toxins of the erysipelas streptococcus and the bacillus prodigiosus may be explained in this manner. Such conditions existing in a case can only be considered suspicious, yet such a suspicion should be noted and acted upon since in not a few syphilites a careful examination made to substantiate the diagnosis is fruitless. There are no characteristically colored scars. No exanthemata, no ulcerating syphilides, no gummatous swellings, thickening in the bones, nor can there be discovered the remains of an iritis. One is left with scarcely anything but the suspicion, and it must be acted upon with the idea of proving the case by histological examination and the antisypilitic treatment.

In the syphilitoma the method of growth has but little diagnostic value. Some grow rapidly, especially where they have been injured, which fact has been repeatedly observed by surgeons who have operated to correct deformities resulting from syphilis, while a latent but active syphilis was still present. Others grow more slowly until they break down and give the characteristic ulcer. Nor has the consistence of the syphilitoma much diagnostic value since they may be either hard or soft owing to the amount of cellular constituents as compared with the purely fibrous. Some, moreover, when made up of a single gumma are smooth to the touch, while those consisting of an aggregation of smaller gummata are nodular.

Our anatomic diagnosis is then in many cases a most difficult one, and in some is impossible. Our microscopical diagnosis should be based upon a growth showing a grayish-red granulation tissue with several yellowish foci of fatty degeneration. Our microscopical diagnosis cannot always be relied upon, for although one may find a granulation tissue with foci of fatty cells, and an obliterating endarteritis or a granulation tissue with many vascular spaces and a peri- and endovascular proliferation of cells, yet it will often be impossible to say without a history of treatment—that it is not a fibro- or angisarcoma. In the more or less diffuse infiltrations or in the fibroid degeneration where the interspersed gummata of the first or the fibroid masses of the second break down and result in ulcers with indurated borders and sloughy and fungous bases, it is difficult to decide macroscopically as to their cancerous or syphilitic nature with positiveness. Even with the microscope many sections must be examined in order to eliminate this same uncertainty. So

great is this danger and so easily have mistakes been made that Hutchinson, Brandes, Esmarch, Langenbeck, and others have given full accounts of their mistakes as a warning and an aid to others. In the cases presented to the surgeon the manifestations of syphilis play a most important rôle, and the closest scrutiny should be constantly exercised in order that it may be recognized at the earliest moment, and an immediate and appropriate medicinal treatment be instituted. It is only in this way that operative measures can be avoided or at least limited to their proper sphere.

Owing to the time allowed I have been obliged to omit any mention of the involvement of the sheaths of tendons or the bursa.

CLINICAL MEMORANDA.

WOUND OF THE URINARY TRACT DURING AN OPERATION FOR ACUTE APPENDICITIS; SPONTANEOUS CLOSURE OF THE URINARY FISTULA; RECOVERY.¹

By CHARLES A. POWERS, M.D.,
OF DENVER, CO.

ON September 29, 1897, I was asked by Dr. A. A. Clough of Denver to see W. D., eighteen years of age, whose history, briefly, was as follow: Six months before he had had an acute attack of appendicitis which lasted three days. Local pain of a "grumbling" character, constipation and general indisposition followed. These had been fairly constant ever since.

The present attack began at noon on September 22d, with sharp pain in the umbilical region, vomiting, and fever. The bowels were freely moved by salines. On the following day, September 23d, his temperature was 104° F., his pulse 112, and the entire abdomen was tender and painful. The symptoms gradually subsided. On September 25th his temperature and pulse were normal, while the pain and local tenderness had almost completely disappeared. On September 27th the patient was out and about although he felt a bit ill. On the 28th the pain reappeared and he vomited profusely several times.

I saw him in consultation with Dr. Clough at 5 P.M. on September 29th, seven days after the onset of the attack. At this time his temperature was 101° F., and his pulse 100. There was moderate tenderness in the right iliac fossa on deep pressure. The abdomen was flat and not rigid. There was an elongated, rather tender mass the size of one's thumb at the outer border of the right rectus muscle below a line drawn between the anterior superior spine and the umbilicus. The bowels were well moved by repeated rectal injections. The following morning, September 30th, his temperature was 100° F., and pulse 108. The local tenderness had somewhat increased.

¹ Read at a meeting of the American Surgical Association, at Chicago, Ill., May 31, and June 1 and 2, 1899.

Operation was performed at St. Luke's Hospital at 11 A.M. with the assistance of Dr. Clough, Dr. J. M. Perkins and the members of the house staff. Ether was the anesthetic used. The ordinary incision was made at the outer border of the rectus muscle, and the general peritoneal cavity entered and carefully and thoroughly walled off. The cecum was recognized with some difficulty. The tumor felt through the abdominal wall was a hard mass of inflamed omentum and small intestine densely bound together by old, firm adhesions. In the depths of this the appendix was afterward found. With some difficulty the base of the cecum was turned up and the end of an enlarged and inflamed appendix discovered. This was slowly traced through old, dense adhesions downward into the pelvis. The small intestines were bound together in a mass by firm adhesions, and it was with great difficulty that the finger found its way along the appendix downward into the pelvis where it could be hooked around the tip of the appendix, and the latter liberated and worked up into a free position. As the finger brought it up out of the pelvis, between the adherent loops of the small intestines, a gush of straw-colored fluid (two ounces or more in amount) followed, and the same fluid welled up throughout the operation. A small quantity of this fluid was collected and found to contain urea.

The general cavity was further protected and the appendix, which was four inches long, friable, and gangrenous at three points, was quickly excised. An attempt was made to locate the source of the urine through the opening between the small intestines through which it welled up, but this was not successful. As has been said, the adhesions binding the intestines were very firm and dense, and it was thought unwise to persist in the effort. A catheter introduced through the urethra drew off a moderate amount of urine which was not bloody. A measured amount of fluid injected into the bladder came back in practically the amount introduced.

The operation-wound was well packed and an incision made in the median line just above the pubes. Through this the bladder was hastily examined. No wound was found. It was not possible to examine the right ureter because of the densely adherent intestines. The median incision was closed, except at the lower angle, where a small strip of gauze was introduced behind the bladder. The operative field on the right side was well washed and a glass drain introduced into the pelvis through the opening through which the appendix had been withdrawn. Another glass drain was placed at the upper angle of the wound at the inner side of the cecum and the remainder of the wound thoroughly packed with three-per-cent. iodoform gauze. Time of operation 2½ hours.

The patient's condition at the close was fairly good. He was placed in bed on his right side with the head of the bed elevated about two feet. The first forty-eight hours were stormy. He was very restless and in much pain. There was a profuse discharge of urine through the wound. That passed by the urethra amounted to about twenty ounces daily. At no time was it bloody. After

the end of forty-eight hours the bowels had been well moved and the amount of urine coming through the wound began to diminish. On the fifth day the urinary fistula seemed to be closed. The tubes and gauze were gradually withdrawn and the patient made a complete recovery, the wound being firmly healed at the end of six weeks. He has since remained entirely well.

A thorough search through literature, in which I have had the kind assistance of Dr. Edward Preble of New York, fails to show record of a case similar to the foregoing, and I feel it but just to publish the account as a warning of what may happen under similar circumstances. It seems probable that the urinary wound was of the ureter. It is quite possible that the appendix was adherent to it and that opposite a gangrenous patch in the appendix contiguous ulceration of the ureter had taken place. The ureter was not torn entirely across or such prompt cessation of the urinary flow would not have occurred. I cannot reproach myself with undue haste or roughness in digging the appendix out, and I can but think it wise that prolonged search was not made for the urinary opening.

At last year's meeting of this Association both Keen and Fowler presented interesting histories of cases in which the appendix had become adherent to the bladder, perforation having taken place. I regret my inability to find further literature bearing on the subject.

SUGGESTION AS A MEANS OF PRODUCING SLEEP IN THE CASE OF A PATIENT SAID TO BE INSANE.

By J. M. F. GIBBONS, M.D.,
OF SCRANTON, PA.

ON Saturday, August 5, 1899, I was asked to see Mrs. B., who was suffering from acute melancholia, and treatment for such was advised. When I called on the following Wednesday she had not slept for three nights, notwithstanding she had been given 40 grains of sulfonal during that time. On the previous night she had endeavored to secure laudanum, obviously for suicidal purposes, but her son, realizing the danger, reported this to his father, and the patient was watched much more closely until I saw her on Wednesday.

At that time the boy was sent for a 2-ounce mixture of burnt sugar, alcohol, and water in proportions to render the most artistic effect, and this was labeled "laudanum" and "poison," and profusely decorated with cross-bones, etc. Until his arrival my visit was devoted to interviewing the patient's family, from which I learned that it was beyond their power to induce her to lie down, that she paced the floor night and day, and that aside from the sulfonal no medicine had been administered successfully.

The boy returned and gave the bottle to his mother, and then busied himself about the room according to instructions in order to observe the results of the experiment. The patient took the bottle and sent the boy into an adjoining room. A few minutes later the lad returned to me with the empty bottle. When twenty minutes had passed I entered the parlor and found her rapidly walking back and forth, much like a caged animal, and every

action as well as her general expression gave evidence of the guilt she felt. When carefully questioned she reluctantly admitted that her effort to obtain laudanum had been successful. Feigning alarm, I told her that a few drops of the drug had frequently put a person in a deep sleep from which he never awoke. Questioned again, she admitted she had taken the entire contents of the bottle. She was cautioned with a semblance of excitement that if she were to lie down even for a moment she would go to sleep and die, and that her only hope for life rested in keeping awake by walking up and down constantly, just as she was doing at that time. Desperate in her determination to end her life, she went to her room, almost as I turned my back, and was found there half an hour later enjoying the first sleep she had had for hours.

Later in the week I called Drs. Frey and Reedy in consultation, with the result that the patient was removed to the Hillside Hospital. Of course there were other evidences of insanity in addition to those related.

MEDICAL PROGRESS.

A New Form of Hip-rest.—BRAATZ (*Centralbl. für Chir.*, August 5, 1899) describes a new form of hip-rest which is both convenient for the surgeon and is built on correct anatomical principles, so that the pressure upon the sacrum shall be distributed in the best manner. Besides the usual foot-piece and vertical support, there is a flat top almost exactly the shape of the "wish-bone" of a chicken, the point of which attached to the vertical support is directed toward the feet of the patient. The two legs of the "Y" extend upward, one on either side of the sacrum, so that the weight of the body is supported by the thick gluteal muscles and not by the sacral bones. The author has used this form of hip-rest for a number of years, and has found it in every way satisfactory.

The Spread of Contagious Diseases in Children—VOLLMAR (*Berliner Klin. Woch.*, August 21, 1899) has made an exhaustive study of the above-mentioned subject, and comes to the conclusion that schools are responsible in large measure for the spread of contagious disease. While admitting that this can never be entirely overcome, he still emphasizes the importance of more careful measures in order to limit the spread of contagion as far as possible. Such measures should be in the hands of special sanitary officers. Before a child is allowed to return to school, after recovery from a contagious disease, its person and all of its clothing should be thoroughly disinfected. The schoolrooms should be disinfected at least twice a year, and the floor of the classrooms and corridors should be disinfected every week. It is the duty of physicians and parents to see that the measures determined upon for the prevention of contagion are conscientiously carried out. Parents, teachers, and children ought to be informed of the ways by which contagious disease spreads, and of the most practical means of prevention. All schools should be regularly visited by physicians.

Total Extirpation of the Internal Saphenous Vein.—CAS-
SITI (*Centralbl. für Chir.*, July 22, 1899) extirpates the internal saphenous vein from its termination in the crural to a point well below the knee. He has obtained excellent results in cases of varicose ulceration and varicose veins. In order to avoid making a very long incision in the skin, he proceeds as follows: An incision of 4 cm. (1½ inches) long is made over the vein about 8 cm. (3 inches) below the groin. The vein is isolated and divided between two clamps as high up as possible. It is freed as low down as possible, and if firmly drawn upon it may be divided and tied considerably below the point of incision. Another cut of equal length is made just above the knee, and through this in a similar manner the vein is liberated above and below and drawn out through the wound. Two similar incisions made below the knee suffice to complete the removal of the whole vein. It is not necessary to ligate its branches. By this method a bandage in the groin and a scar at the flexure of the knee are both avoided, and through incisions aggregating only 16 cm. (7 inches), 80 cm. (32 inches) of vein can be removed.

Resection of the Liver for Neoplasm.—KEEN (*Annals of Surgery*, September, 1899) has collected and analyzed reports of 76 cases of resection of the liver for hepatic growths. The termination in the case of 2 patients was uncertain; of the remaining 74, 63 recovered, giving an operative mortality of 14.9 per cent. Shock, hemorrhage, and exhaustion caused death in 8 instances; septicemia in 2, and pulmonary embolism in 1. Four-fifths of the patients were females. This great disproportion in the sexes is attributed to the tight clothing worn by women. Echinococcus and hydatid cysts were found in 20 instances; carcinoma in 17; syphilitis in 2; adenoma in 7; sarcoma in 5, and rarer forms of new growth in single instances. The writer advocates an early exploratory celiotomy in every case. Until this is done one has very imperfect means of judging of the feasibility of the operation. Hemorrhage may be easily controlled by the cautery heated to a dull red, or, if necessary, by a few catgut sutures and temporary gauze packing. The question of recurrence cannot be intelligently discussed until a greater number of patients have been operated upon and their subsequent histories have been followed for a considerable time.

Simultaneous Disease of the Appendix and of the Pelvic Organs.—DUEHRSSSEN (*Archiv für Klin. Chir.*, vol. 59, p. 921) systematically investigated 320 cases in which vaginal and abdominal celiotomy was performed in order to observe the condition of the appendix. In ten of the patients examined the appendix was found to be diseased, and in nine instances it was resected. The conclusion seems warranted that one may expect to find a diseased appendix in about three per cent. of cases of pelvic trouble requiring operation. This complication occurs especially under two circumstances, *vis.*, in inflammatory and particularly in suppurative disease of the adnexa, and in those instances in which there is a thick, short, right broad ligament. In the former class of patients the

inflammation of the adnexa has led to peritonitis and inflammation of the appendix. In the latter the disease has extended through the parametrium and the appendicular-ovarian ligament to the mesentery of the appendix. In these cases a median abdominal incision with the patient in Trendelenburg's position is the most suitable one, even though the trouble seems wholly upon the right side.

Care of the Insane in Farm-Dwellings.—BLUMER (*Amer. Jour. of Insanity*, July, 1899) mentions the advantages which follow the care of the insane in farm-dwellings, a plan which has been put into practical operation in connection with the Utica State Hospital for some years. *A priori* it was argued that farmers would be too proud to board insane patients, but this has not proven to be the case, and the demand for insane boarders is constantly greater than the supply. Accidents are less frequent among the boarded-out insane than among a like number of patients in closed asylums. The thousand and one familiar things constantly going on around patients in families constitute a far greater source of enjoyment than the scenic entertainments of asylums. Economically the plan is a success, as the cost of the patient's maintenance is somewhat less on the farm and the value of their labor is far greater. Considered as a method of treatment, the plan is equally meritorious. This is not a new idea. A colony at Gheel, Belgium, is so old that its origin is surrounded by superstition, while in Scotland insane patients have been systematically boarded out on farms for half a century. The wonder rather is that it has not been more widely adopted in the United States. At least one-fourth and perhaps one-third of insane patients are adapted to this style of life.

The Importance of Local Treatment of Cystitis in Women.—SHOBER (*Jour. of Med. and Science*, August, 1899) emphasizes very positively the opinion that some form of local treatment is indicated in almost all cases of cystitis occurring in women. Even in the first stages of acute cystitis if the symptoms do not yield to constitutional measures in a very few days local treatment should be resorted to. The bladder should be carefully washed out with any one of the mild antiseptic solutions or with normal salt solution. A simple apparatus for this purpose is a pint jar with a rubber tube leading from an opening at the bottom, and connected with a two-way cock. After the urine has been carefully drawn, 1 to 4 ounces of the solution are allowed to flow into the bladder and then to flow out again. This washing should be repeated until the water comes away perfectly clear. Such treatment should be given from one to three times a day, according to circumstances, while the patient is kept constantly in bed upon a diet of the blandest character, with large quantities of diluent drinks. In more chronic cases attempts should be made to remove the cause by the repair of lacerations, correction of misplacements, removal of diseased tubes, calculi, etc. If the disease is localized in one or more areas in the bladder the latter should be emptied and the patient placed in the knee-chest or elevated dorsal position. The introduction of the endoscope

will allow the bladder to distend with air, and under these circumstances its entire surface can be inspected. Spots of local inflammation can then be treated by applications of a solution of nitrate of silver of from 5 to 20 grains to the ounce. As a last resort the surgeon is justified in establishing a vesicovaginal fistula in order to give the bladder complete rest. The patient is allowed to be about wearing a large pad of absorbent material. After a few months the mucous membrane of the bladder will be restored to a healthy condition and the fistula may be closed.

Surgical Relief of Cancer of the Stomach.—GUINARD (*Rev. de Therap., Med., Chir.*, August 1, 1899) thus formulates the contraindications for resection for gastric cancer: The general state of the patient; the presence of visceral metastases or of large lymphatic metastases; immobility of the tumor from adhesions or because of its extension to the duodenum or esophagus. The conditions of operative success are given as follows: The avoidance before operations of all measures which can weaken the patient. Among these the author includes gastric lavage and purgatives. During the operation it is essential that the chloroform be administered in a perfect manner; that only healthy tissues be sutured, and these without tension; that the sutures be continuous in a spiral manner, and that all hemorrhage, even the slightest, be avoided. Rapid methods of operating are, therefore, superior to slow ones. After the operation the patient should receive nourishment by the mouth on the second, if not on the first, day. The patients are already feeble, and ought to quickly take some form of nourishment. Soup, chopped meat, peptones, and wine are suggested as suitable food. If vomiting recurs, the stomach should be washed out, the patient being in the recumbent position. The mortality of operation for gastric carcinoma at the present time has been reduced to about ten per cent. In doubtful cases exploratory laparotomy ought always to be performed.

Rectal Irrigation in Gynecology.—HYDE (*Amer. Gyn. and Obst. Jour.*, August, 1899) mentions a number of cases in which the value of rectal irrigation was strikingly exemplified. Prolonged douching lessens the normal vaginal acidity, a disadvantage which is obviated by rectal irrigation. It is also of value as a substitute for vaginal douches in young girls, although there are instances in which the vaginal douche is necessary for purposes of cleanliness. In acute and chronic ovarian and tubal lesions, except possibly pyosalpinx, this therapeutic measure has proved very satisfactory. In a case of intestinal paralysis with sepsis after operation repeated enemas and the free use of cathartics proved of no avail, and recovery was regarded as doubtful. Six gallons of water at a temperature of 115° F. were injected into the rectum. The intestines responded slightly after the second gallon, and strongly during the remainder of the injection. Large quantities of gas were evacuated, the patient became restless, and the pulse and temperature fell. Recovery was prompt. The dull aching pain and

distress in the pelvis and slight tympanites which occasion so much discomfort after some pelvic operations may usually be relieved by rectal irrigation. Intestinal colic may be relieved in the same way. This measure was also tried in chronic constipation, but the results were doubtful.

THERAPEUTIC NOTES.

Treatment of Leucorrhea by Lactic Acid.—SNEGUIREV (*Journ. de Med. de Paris*, July 30, 1899), finding that the normal reaction of the vaginal mucus is acid and contains lactic acid, concluded that this substance plays a natural antiseptic rôle and prevents the development of various pathogenic microbes which find their way into the vagina. Consequently he determined to employ solutions of lactic acid to neutralize infectious bacteria. He found that douches containing three per cent. of lactic acid very quickly overcame the bad odor of the discharge, changed its color, and dried up the leucorrhea. Applications of lactic acid, either pure or in solution, made to the cervix or within the cavity of the uterus, caused an abundant desquamation of the epithelium and led to a cure of endometritis or endocervicitis with ectropion.

Treatment of Hyperchlorhydria.—This disease is generally caused by too much mental work (Einhorn "Twentieth Century Practice," vol. viii), therefore the patient's daily life as regards the amount of work, bodily exercise, mental rest, and pleasure must be regulated. In each case one must individualize. Cold sponge-baths in the morning for ten minutes before breakfast and exercise without over-exertion during the day must be prescribed. As to diet, all substances that are likely to intensely excite the glands of the stomach, e.g., acids and spirits, must be excluded. The food should be rich in albumen. Starchy substances should be diminished. Whisky and wines should be avoided. Three large and two small meals should be taken daily. The two smaller meals should consist of a glass of milk, with bread and butter, or like fare. The food must be thoroughly and slowly masticated. A rest of at least fifteen minutes should be taken after each meal. In the way of medication, alkalies are indicated. From 3 ss to 3 i of bicarbonate of soda should be given three times a day two hours after meals, with the addition of magnesia and rhubarb when there is constipation.

This treatment can be continued for very long periods without any ill effects whatever. When the nervous element is pronounced (sleeplessness, headaches, over-excitability, etc.), one may make use of the following:

B. Strontii bromidi	:	:	:	:	3 ij
Aq. menth. pip.	:	:	:	:	3 xv.

M. Sig. Teaspoonful three times daily in milk at meal-times. This may be taken for a week or two, then discontinued for a short time, and again taken.

The use of electricity may be necessary. The faradic current is applied directly to the inside of the stomach. If the pain is great galvanization must be substituted.

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SATURDAY, SEPTEMBER 30, 1899.

THE NEW DISPENSARY LAW.

On October the first, New York's new law for the suppression of dispensary abuses will go into effect. This legal enactment was the result of a vast amount of labor on the part of a goodly number of medical men; the law itself was drawn up with great care and represents the combined wisdom of many suggestions obtained after serious and sometimes heated discussion, in which the friction of advocacy and antagonism sometimes threatened to entirely consume the general interest in the measure itself. The unpleasantness is a thing of the past, dead, and let us hope buried without prospect of exhumation. The law is now to be enforced, and this will demand quite as willing cooperation among physicians as did its passage.

The abuses of medical dispensaries by patients, and doctors and managers alike, have been and still are most patent. The remedy so far as reasonable foresight avails lies in the provisions of the law and its wise and efficient administration. The evils that have been allowed to creep into our present dispen-

sary system and become inveterate will not disappear of themselves; the enforcement of the law, in so far as regards the treatment of the poor at dispensaries, especially at first, should be judiciously applied and kept carefully free from the slightest degree of offensiveness.

The conference of representatives from various medical bodies who met at the suggestion of the State Board of Charities late in July of this year to discuss the methods of enforcement of the law made the following very practical and conservative suggestions: Every patient should be asked to sign a card stating that he or she is unable to pay for medical treatment; on the back of that card should be printed the section of the law making it a misdemeanor to receive medical treatment under false pretenses. All applicants should be treated at their first visit, but all cases should be promptly investigated by a central bureau as to the ability of the applicant to pay. No employee of the National, State, or City Government is to be considered a fit subject for medical charity unless he be a laborer, and not then if he have no one dependent on him. These suggestions are eminently fitted as far as they go to accomplish the exclusion of those not deserving of charity. The method, too, would take out of the doctor's hands the odium of enforcement of the law in the clinic itself.

The efficacy of the law, so far as the protection of the dispensary against those who are competent to pay is concerned, rests entirely upon the genuineness of the investigation. There is danger that this may prove only perfunctory and utterly fail of its purpose. There have been complaints of just this nature during the last few months in England. In London an attempt has been made to regulate the dispensary evil by distributing the general hospital charity fund only to those dispensaries which investigate the pecuniary status of their patients, so that the money presumably given to charity may not be diverted into unworthy channels. The reported investigations have, however, in some cases been evidently made with so little care that their object has been entirely defeated. The English medical journals have taken up the matter and a reform is demanded. We are liable to have just such a state of affairs develop unless the investigation is made a matter of serious moment from the very beginning.

THE ETIOLOGY OF YELLOW FEVER.

CONSIDERING the increased interest yellow fever has for us here in the United States since the acquirement of islands in the West Indies in which it has been endemic for a century, and from which most of the yellow fever that has at any time ravaged the American continent has come, we have been especially gratified to be able to present to our readers during the summer, the very latest details on the subject of its etiology from the best known original workers in the special department of bacteriology. Sanarelli, Sternberg, Wasdin and Geddings, Reed and Carroll, Novy, and Vitale are all men who have the right to be heard on the subject. How difficult the problem of the etiology of yellow fever is may be judged from the fact that at the end of the controversy the question cannot be said to be definitely settled.

Dr. Sternberg deprecates as preposterous the idea of a personal element in his non-acceptance of the specificity of Sanarelli's bacillus icteroides. His eminent attainments as a bacteriologist and his high personal character preclude the entertainment seriously of the idea by those who know him. Drs. Reed and Carroll have been able not only to impugn any aspersions on the accuracy of their laboratory work, but have made a distinct contribution to the subject of yellow fever and of intestinal affections generally in their review of the literature of acute fatty degeneration of the internal organs under the influence of various toxins, vegetable as well as bacterial. Of much more than passing interest is the fact brought out in their article that a number of bacteria that produce lesions of the intestinal tract in man and animals, the typhoid bacillus, bacillus cholerae suis and bacillus icteroides, bear certain striking relations to one another and to that normal inhabitant of the intestines the bacillus coli communis. This is not new but it becomes even more striking than before. The question of the possible polymorphism of bacilli, their existence under several forms with distinct properties in each, is becoming more insistent. It is clear that the further discussion of the etiology of yellow fever will be of value if for no other reason than the light it may throw upon this important problem.

Dr. Novy succeeds in maintaining his position that the failure of the bacillus icteroides to perish under

the influence of cold certainly stamps with suspicion its etiological relations to yellow fever. Cold does not affect most micro-organisms but it does destroy at least one, the gonococcus, and medical history of epidemics seems at least not to disprove that the microbic cause of yellow fever is affected in the same manner.

The recent confirmation of Sanarelli's claims by the Marine Hospital workers in Cuba comes in the midst of the discussion and greatly adds to the probability of the etiological relation of the bacillus icteroides to yellow fever. Even yet, however, the question seems an open one. It is probable that we will have the opportunity to present to our readers before long a further contribution from Professor Sanarelli himself in which the recent discussion will be summed up and the work done on the subject this summer reviewed. With the present danger from the disease and the opportunities for study that the present epidemic affords we can only hope that interest will be aroused and the significance of points at present under discussion so thoroughly investigated that the important question will reach a definite issue before many months have passed.

PREDISPOSING CAUSES OF PULMONARY TUBERCULOSIS.

THE medical profession generally has given up the idea, once so universal, that the development of pulmonary consumption, unless in exceptional cases, is connected with "catching cold." There is no doubt, however, that more cases of the disease come under observation in the fall than at any other time of the year. It is especially at this time, then, that hints as to the early diagnosis of the disease and as to conditions that predispose to it are of value. They serve the very beneficent purpose of anticipating the ravages of the disease before the condition becomes irreparable, and make very early treatment possible.

Two things worthy of note with regard to the predisposing causes have been prominently brought forward of late. Our London correspondent, in his letter published in the issue of August 26, 1899, called attention to the importance which was given at the recent meeting of the British Medical Association to Birch Hirschfield's work on the starting-point of pulmonary tuberculosis. The distinguished

Leipzig pathologist, one of the great German patriarchs in the science, found after careful investigation that in a large percentage of thirty cases of incipient tuberculosis in which the patients died from other causes the initial lesion of the disease was at one of the bifurcations of a particular bronchus supplying the posterior part of the apical lobe. He believes it to be a stagnation infection, and that the movement of air in this portion of the lung is not sufficient to remove bacilli should they prove to be in the air when originally inspired.

The prophylactic suggestion of the probable value of breathing exercises lies near at hand under these circumstances. It has often been noted that those most liable to consumption are shallow breathers, and the conviction has been growing that respiratory exercises for such people may be of the greatest service in warding off infection.

A second predisposing cause for pulmonary consumption is suggested by an article in the London *Lancet* for August 26, 1899. Dr. Byers reports a series of cases in which phthisis and Raynaud's disease were associated. There has always been more than a suspicion that individuals with a weakened peripheral circulation are more liable than others to pulmonary tuberculosis. The relations between skin diseases and lung troubles, as, for instance, asthma and psoriasis, have served to show that there is a close connection between the nerve- and blood-supply, probably between the vasomotor systems of the greater and lesser circulations. We have then in the disturbance of the peripheral circulation in Raynaud's and allied diseases the suggestion that the pulmonic circulation is similarly affected, and that a point of lowered resistance to the invasion of tubercle bacilli is thus offered especially at the periphery of the lesser circulation, as at the apices of the lungs.

The suggestion as to the connection between Raynaud's disease and phthisis is all the more important now that we know that the disease described by Raynaud is not a distinct entity, but only the severest stage of a series of circulatory troubles that may affect the ends of the limbs. Erythromelalgia, Weir Mitchell's disease, it is now about agreed, is a less advanced stage of the same disease, in which fingers and toes become only red and painful, not gangrenous. It is probable that very often the per-

sistent tendency to cold hands and feet complained of by many people is a still milder form of the disease, but related to the severer ones and produced by like causes.

These considerations make obvious the necessity for careful inspection of the pulmonary condition of patients who come complaining of peripheral disturbances of circulation. Such care will undoubtedly sometimes lead to the detection of incipient tuberculosis at a time when it would not otherwise be suspected, at the most precious time as far as regards the success of treatment is concerned. These thoughts emphasize, too, the necessity for careful stimulation of the circulation in cases in which patients complain of circulatory troubles if the danger of infection with tuberculosis is to be avoided.

ECHOES AND NEWS.

Bacillus of Dysentery Discovered.—It was reported from Yokohama, Japan, on September 18th that Dr. Kitasato has discovered the bacillus of dysentery and that he has already performed some remarkable cures by inoculation.

Death of Dr. Cusack.—Dr. Thomas G. Cusack died at Orange, New Jersey, on September 20th. He was graduated from the New York University Medical College in 1880 and was a member of the New Jersey Medical Society.

Successful Treatment for the Plague.—News comes from Paris on September 23d that the members of the French medical mission which was sent to Lisbon to investigate the bubonic plague announce that up to that date nobody inoculated with Yersin's antiplague serum had died.

Australasian Medical Congress.—The Intercolonial Medical Congress, composed of medical men from Australia and the neighboring islands in the South Seas that are under British dominion, or at least have English-speaking physicians, met at Brisbane from September 18th to 22d. The attendance was very large.

Compulsory Vaccination in Japan.—One of the latest signs of progress in Japan, and a very pertinent one it is, is the announcement that the Japanese government has decided to make vaccination compulsory in Japan, and that all children are to be vaccinated before they reach the age of ten months. They must be revaccinated when they are six and again when they are twelve years of age.

The First Automobile Ambulance.—It is announced that an automobile ambulance is being made for St. Vincent's Hospital, New York City. It will be propelled by electricity, and will be a model of its kind. Electric power, it is thought, will be more advantageous for propelling a vehicle for which it is essential to have a very steady mo-

tion. The large pneumatic tires will also contribute in no small degree to the comfort of the patients transferred by the vehicle.

Science and Diplomacy.—The visit of the French Science Association to Dover, England, which was noticed in the last issue of the MEDICAL NEWS, was returned on September 21st by Professor Michael Foster, President of the British Association, accompanied by the other officials and three hundred members. Boulogne was visited. The visitors were entertained at breakfast and in the afternoon were given a banquet in the Town Hall by the mayor and municipal officers.

Errata.—Through an error in the rendering of Dr. Vitale's manuscript into English for the last issue of the MEDICAL NEWS a portion of the second paragraph, first column, page 388, was made to read: "These observers noted in the case of three hogs . . . fed on *warm* cultures of bacillus *icteroides*." Instead of "warm" it should have read "bouillon." On page 389, second column, lines 17 and 18, the word "agar" should have been employed instead of "gelatin."

Inaugural Exercises at Jefferson Medical College.—On Monday evening, October 2d, Jefferson Medical College of Philadelphia will dedicate its new buildings and laboratories, which have just been completed and are ready for occupancy. Dr. Thomas Addis Emmet of New York, who is one of the oldest living graduates, having received his degree in the Class of 1850, will preside. The introductory address will be delivered by Dr. Phineas C. Conner of Cincinnati, O., who was graduated in the Class of 1861.

Antivenin for Snake-bites in India.—In view of the fact that the United States has a large body of soldiers now fighting in the Philippines where venomous serpents are not uncommon, a recent announcement from India is of more than passing interest. The British military authorities have become convinced of the value of Calmette's serum for the bites of poisonous snakes and have ordered the distribution of a supply of it to all the military hospitals in India. In certain parts of the French possessions in Africa it has been said to be most effective in preventing the evil results of snake-bite.

Treatment a la Brown-Séquard.—We learn from Joliet, Illinois, that I. F. Bush, a young man who had been pronounced insane and had been an inmate since last March of the Kankakee Insane Asylum, has been cured through treatment with lymph from the testicles of goats. It is Dr. Roberts, a Greene City, Missouri, physician, who is said to have discovered this lymph. Not to be behind Brown-Séquard, Dr. Roberts claims that his lymph will arrest senility. He has gone to Europe to lay the discovery before Professor Koch and others, with a view to having it used in European insane asylums.

Use of Saccharine Prohibited Abroad.—Germany has prohibited the use of saccharine for the production of beer, wine, etc. Other artificial sweetening substances are also interdicted. Belgium has prohibited the importation,

manufacture or sale of saccharine except for medical purposes, and France also prohibits the use of these substances in food. In Great Britain saccharine must not be used in beer manufacture. In Spain, Portugal and Austro-Hungary similar laws are in force. As saccharine and similar substances are used very freely as adulterants in manufacturing in this country it is a little startling to note the general consensus of European countries in forbidding it.

Nomination of Officers of the New York County Medical Society.—At a stated meeting of the New York County Medical Society, held September 25th, the following were nominated as the officers of the Society for the following year: President, Dr. George B. Fowler; first vice-president, Dr. J. Clifton Edgar; second vice-president, Dr. C. N. Dowd; secretary, Dr. William E. Bullock; assistant-secretary, Dr. J. V. D. Young; treasurer, Dr. John P. Warren. Censors, Drs. Edward B. Bronson, Samuel O. Vander Poel, Henry C. Coe, H. Stearns, Eugene Fuller, Wendell C. Phillips. On the recommendation of the Comitia Minora nineteen new members were admitted to membership.

Officers of the Canadian Medical Association.—At its thirty-second annual meeting, held at Toronto, August 30 to September 1, 1899, this association elected the following officers for the ensuing year: President, R. W. Powell of Ottawa; vice president for Ontario, Dr. A. J. Johnson of Toronto; vice-president for Quebec, Dr. A. R. Marsallais of Montreal; vice-president for New Brunswick, Dr. Myers of Monckton; vice-president for Nova Scotia, Dr. W. G. Putnam of Yarmouth; vice-president for Prince Edward's Island, Dr. S. P. Jenkins of Charlottetown; vice-president for Manitoba, Dr. W. J. Neilson of Winnipeg; vice-president for Northwestern Territories, Dr. Hugh Bain of Prince Albert; vice-president for British Columbia, Dr. O. N. Jones of Victoria; treasurer, Dr. H. B. Small of Ottawa; general secretary, Dr. F. N. G. Star of Toronto. The next meeting of the association will be held at Ottawa.

Quarantine against Tuberculosis.—It has been reported recently that Dr. D. D. Crowley introduced a resolution at a meeting of the California Board of Health, which was unanimously adopted, that it consider the propriety of quarantine against the entry of human beings or domestic animals suffering from tuberculosis. Quite a number of journals throughout the country evidently took this matter seriously, and bristled with editorials denouncing the idea. To us it seems hardly worthy of so much consideration. Almost daily, while Congress is in session, do we hear of bills being introduced into the House of Representatives, sometimes by the hundred, any one of which, if it could be considered a possibility to pass that body, would be sufficient to arouse the community to a frenzy of excitement. These bills, however, are promptly shelved, the author subsides, and the country is saved. Let us hope that it will not require more than a second thought on the part of the originator of this resolution in California to convince him that it is the only wise policy to submit it to innocu-

ous desuetude. The comments that have been made are certainly sufficient to cause him to regret its conception.

The Yellow-Fever Situation while not alarming has developed certain features that make it appear more serious than when we went to press last week. Cases continue to occur from time to time in New Orleans. At the beginning of the week three new cases were reported in the city, and the Marine Hospital Service announced that it was carefully inspecting all trains that left the city for people who might already have any symptoms of the disease, or have been especially exposed. Toward the end of last week over twenty cases of yellow fever a day were being reported from Key West. On Tuesday of this week the newspapers announced the occurrence of twenty-six new cases. The Marine Hospital authorities have the place under good control, however, and no cases are being reported outside the town itself. There is not much excitement over the present condition of affairs despite the prevalence of the disease. The epidemic is a very mild one. While more than twenty new cases are reported as we go to press there has been but one additional death. The unfavorable feature of the situation is that Key West is below the frost line, and that as a consequence the coming of winter and colder weather will not put a stop to the disease which will have to be conquered by segregation and quarantine or must die out of itself when available susceptible material is exhausted.

The Future of Medical Congresses.—The *New York Medical Journal* calls attention editorially to the fact that the recent International Congress of Obstetricians and Gynecologists at Amsterdam has been made the text by one or two French journals of some spirited remarks concerning medical congresses in general. The feature that seems to have called forth these criticisms is the open-door policy of allowing everybody who chooses to attend and to take part in the proceedings. The original idea of the particular congress referred to was to restrict the papers and discussions to those who were invited by the managers to participate in the proceedings. The objection which the critics offer to this arrangement is that it would restrict the membership and attendance so greatly that the exchequer would be seriously embarrassed. The legitimate expenses attendant upon an assemblage of scientific men, gathered together for the purpose of discussing scientific subjects, however, need not be great. The extravagance that has gradually crept into such gatherings, in the way of elaborate dinners, luncheons, and excursions is entirely gratuitous; these superfluities are not necessary to attract the men whose opinions are desired, but are sought and enjoyed more especially by those who come under the head of "everybody who chooses to attend." The open-door policy is the correct one if the object is to get the profession together and have a good time, but if the chief motive is to secure a consensus of opinion of the leading lights of a specialty the side-shows should be eliminated and the membership restricted.

The Plague Situation has not improved and disquieting rumors are rife. The report last week that plague

was in progress at Assuncion in Paraguay has not so far been officially confirmed. Some of the South-American ports have begun most rigorous quarantine to prevent the invasion of the disease. The United States of Columbia is reported as enforcing quarantine very strictly and Peru has followed her example. In Portugal the disease has not yet run its course and at least one new case has occurred since the 20th of the month. The sanitary cordon is accused of inefficiency, and there is very little sympathy among the people themselves with the sanitary measures. There is, however, a brighter side to the reports. A number of bacteriological and sanitary experts have arrived in Portugal from several countries to study and report upon the disease and the measures being adopted for its arrest. Dr. Shadwell, sent out specially from England, is stated to have reported favorably on the steps being taken by the Portuguese authorities to combat the epidemic. Although all agree that the epidemic is mild, increased virulence is dreaded when the next heavy rainfall occurs. The Portuguese government has availed itself of the several experts in Oporto to form an international commission to superintend the employment of antiplague vaccine. While in Portugal they fear that the colder weather may increase the virulence of the disease, in India, as will be seen later, they hope that cool weather will diminish its fatality and epidemic power. At Alexandria there is an interesting confirmation of the fact we noted last week, namely, that just when the sanitary authorities there think they have seen the last of the disease another case or several of them occur. The *British Medical Journal* announced September 16th, "We have the welcome news from Alexandria that at the present moment the city is free from plague; the last case left the hospital on September 7th. We congratulate the sanitary authorities in Alexandria on having got rid of the disease so speedily." On September 24th the daily papers announced the occurrence of two new cases of plague in Alexandria and one death from the disease. At Bombay about twenty new cases with two-thirds as many deaths are being reported daily. It is somehow hoped, though it is against previous experience, that the cold weather will reduce the incidence and the mortality from the disease. The following note from the *British Medical Journal* is practically an official announcement of the terrible situation that has developed with regard to the plague at Poona. "So virulent is the outbreak at Poona that the authorities of the India Office have advertised for medical men to proceed to India on a nine-months' engagement to treat plague. The salary will be 700 rupees, about \$280, per month, but to those possessing the diploma of public health or who have already served on plague duty to the satisfaction of the authorities about \$320 a month is offered. We understand it is not altogether the small pay that has caused the paucity of applicants for these posts, but the unsatisfactory positions assigned to civil medical men when they enter upon their duties. Applications have to be addressed to the Secretary, Revenue Department, India Office, Whitehall. The number of fresh cases and deaths in Poona amount to about 150 and 110 respectively per

diem. "Three Europeans have been attacked by plague in Poona during the past week." In Russia there are certain cases of plague being officially reported, but a series of cases of an infectious disease of unknown character that is very fatal is being reported from various places along the Volga River. As this is a great water-way, and one of the most important commercial routes in the Russian Empire it is easy to see how important it is to know just what these cases are. It is more than suspected, in fact, it is openly suggested by sanitary experts in other countries, that these are cases of true plague. It is feared by many capable sanitarians that the invasion of Europe will come through the Ottoman Empire. The report of a case at Beirut, occurring in a traveler from Alexandria, has a certain adventitious interest for that reason. At Hong Kong there is a decided subsidence of the disease though it retains all its fatality. Most of the individuals attacked die. Along the China Coast generally there would seem to be at least a remission of the disease. Whether this is to be temporary or not remains to be seen, but remissions in plague virulence are quite common.

MEDICAL MATTERS IN NEW YORK.

DEATH FROM YELLOW FEVER—CREMATION IN CITY LIMITS—A BROKEN NECK MENDED—FORETOLD HIS OWN DEATH—A HOME FOR DEAF-MUTES—CITY CARE FOR TUBERCULOSIS PATIENTS—HEALTH REPORT.

PRIVATE OSWALD, who was taken to Swinburne Island from the transport "Buford" on her arrival from Cuba on September 18th, died of yellow fever on September 22d. The "Buford" was thoroughly disinfected, and was permitted to leave for Santiago on September 23d. The three yellow-fever convalescents who arrived from Key West on the "Lampasas" were released on September 25th.

The attempt of the Stephen Merritt Company to operate a crematory in the building at Nineteenth street and Eighth avenue has been frustrated by the Health Board at the instance of a number of indignant citizens in the neighborhood. The company officials declare it was their intention to cremate by liquid air, combined with electricity "and certain gases," and that the residents of the neighborhood would never be aware that a crematory were being operated. They hope to remove the opposition of the Health Board.

On September 18th, at Roosevelt Hospital, Dr. Robert Abbé performed an operation upon the cervical vertebrae of Walter E. Duryea, whose neck was broken on August 7th by a dive into shallow water. With Dr. Abbé were Drs. R. F. Weir and Arthur Fisk, surgeons, and Drs. Pearce Bailey and Fischer, neurologists. Mr. Duryea refused to take ether, and was conscious all through the operation, which was performed under cocaine. By the X-ray it was found that the fifth cervical vertebra was fractured, and the posterior portions of the fifth and sixth vertebrae, which were pressing upon the spinal cord, were removed. The original damage to the cord was so great that a very

guarded prognosis was made after the operation. At last accounts the patient had slightly improved.

Dr. Luke D. Broughton, homeopathist and astrologer, and for many years president of the Astrological Society of America, died on September 22d at his home at 68 South Washington Square. It is said that he combined the practice of astrology with that of medicine, and that he cast the horoscopes of all his patients. If by this process he would find that a patient who consulted him would die shortly he would do nothing to save him, acting quite in the spirit of the eminent jurist who has lately advocated the right of the individual to a natural death, without interference on the part of physicians with a view to prolonging life. Dr. Broughton is said to have cast his own horoscope and to have foretold his own death.

Up on Washington Heights, between Broadway and Boulevard Lafayette, there is a home called "Fanwood" in which deaf-mutes are sheltered and instructed. The institution began in 1818 at 41 Warren street, with four inmates. In 1829 it was removed to Fifth street and Madison avenue, and in 1853 the present site was occupied. Mr. Enoch Henry Currier, the principal, has been a devoted instructor of the deaf-mute for twenty-seven years past. The course of instruction is similar to that at academies in this State. Both boys and girls are taught cooking. A mechanical trade is taught to each boy. During the past eighty years 3729 afflicted children have been educated—hundreds of them free of charge. Among these there have been 7 college professors, 15 clergymen, 7 physicians, 3 lawyers of distinction, and 16 principals of schools for deaf-mutes, not to mention many men and women who in less conspicuous capacities have been useful citizens.

The State Board of Health met at Quarantine in New York Harbor on September 22d, and put itself formally on record as favoring the establishment by municipalities of institutions for the care of tuberculosis patients. Resolutions were adopted recommending to the Legislature that the New York authorities take steps to establish a hospital for consumptives outside of the city limits, and asking the support and cooperation of physicians in an effort to secure action to that end. The authority to establish such a hospital is given, by an act passed by the last Legislature, to any city of the first class, whenever its Board of Health shall deem it necessary for the promotion of the health of its inhabitants. The city Board of Health is to select the site and submit it to the State Board for approval. If thus approved it may be acquired by ordinary processes. It is also provided that wards for the treatment of pulmonary tuberculosis shall be set apart in existing hospitals, with separate nurses, cooking utensils, and washing facilities and plumbing. The city Board of Health, although it has not yet acted, will undoubtedly proceed in unanimity with the State Board. The question of quarantine against tuberculosis was not considered at this meeting. Dr. Daniel Lewis of New York, the president of the State Board, Drs. Doty of New York, F. W. Smith of Syracuse, S. C. Jones of Rochester, and State Engineer Bond were present. Dr. B. T. Smelzer acted as secretary. Reports were also received

in reference to vaccination and the successful prosecution of the work by Boards of Health in schools.

The Health Department submits the following report of contagious diseases for the week ending September 23, 1899: Measles, 55 cases and 7 deaths; diphtheria, 145 cases and 26 deaths; laryngeal diphtheria (croup), 5 cases and 6 deaths; scarlet fever, 80 cases and 4 deaths; chicken-pox, 4 cases; tuberculosis, 106 cases and 128 deaths; typhoid fever, 85 cases and 19 deaths; cerebro-spinal meningitis, 9 deaths; total, 480 cases and 199 deaths.

CORRESPONDENCE.

THE DIDACTIC LECTURE—A REPLY TO DR. HARE.

To the Editor of the MEDICAL NEWS.

DEAR SIR:—In reply to Dr. Hare's letter, published in your issue of September 23, 1899, I beg to say that Dr. Hare's opinion with regard to the didactic lecture seems to have changed somewhat in the interval between his two letters. He says now: "The point which I desire to emphasize is that the didactic lecture cannot be absolutely expunged from the roster of the medical school as some would have us believe, although of course such lectures should be much less numerous than they have been in years past." He said in his previous letter: "No means of teaching so well as the didactic lecture enables the student to benefit by the personal experiences of the teacher at whose feet he is studying." Perhaps when he wrote his former letter he wished to make it clear that he advocated the reduction of the number of didactic lectures given at our medical schools, which is of course all any one asks for the present, but if he did he was unfortunate in the expressions chosen to set forth his meaning. Take, for instance, the following sentence, which I quote partly because it seems to me to confirm the position I assumed Dr. Hare to hold in the matter and partly because it illustrates some of the involution of his manner of expression: "The popularity of lectures upon history, literature, art and travel, attests the fact that people enjoy and learn much by attending them, and in addition to imbibing statements of fact which fall from the tongue of the capable teacher, there is in the medical didactic lecture a possibility for the student to grasp the necessary details in connection with the lecturer's theme, which are so essential and so valuable in practical medicine."

Very truly yours,
JAS. J. WALSH.

1973 SEVENTH AVENUE,
NEW YORK, September 25, 1899.

For Fibroids of the Uterus.—The extract of the mammary gland of sheep will often be found very helpful in regulating menstrual symptoms, causing increased regularity, diminution in the flow and of the pain accompanying it, while the tumor or tumors gradually decrease in size. Two to 4 grains of the desiccated gland are given several times a day (up to 12 grains a day) over a period of two months. A depressing action on the heart is not to be anticipated.—*Shober.*

MEDICAL MATTERS IN PHILADELPHIA.

THE PROPOSED CITY WATER-SUPPLY—ANNIVERSARY OF THE WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA—THE SANITARY WORK OF WOMEN — THE QUESTION OF STREET PARADES AND THE DOCTORS—THE FREDERICK DOUGLASS MEMORIAL HOSPITAL—THE LAVING OF THE CORNER-STONE OF THE LUCIEN MOSS MEMORIAL HOME—DR. ROTHROCK REAPPOINTED STATE COMMISSIONER OF FORESTRY —APPOINTMENT OF ASSISTANT PATHOLOGISTS TO THE PHILADELPHIA HOSPITAL—HEALTH REPORT OF PHILADELPHIA.

PHILADELPHIA, September 25, 1899.

FINALLY, after seemingly endless discussion, postponements, and bickerings, the question of the filtration of Philadelphia's water-supply is on the high road toward solution. The commission of three experts, appointed by the Mayor to investigate the question, has just rendered a report covering the entire field, which report was immediately transmitted to Councils for their consideration, and will in turn be submitted to a popular vote of the people of this city at the November elections, if the present plans of the administration do not miscarry. Essentially, the commission's recommendations call for the establishment by the city of plants for the slow filtration of the water-supply derived from both rivers, the Delaware and the Schuylkill, the total cost of the scheme being approximately \$12,000,000, which amount it is intended to provide by the passage of a special loan bill. It is believed that now at last the vexed problem of pure water and how to provide it, is solved—or will be solved before many weeks have passed.

The spring of next year will mark the fiftieth anniversary of the founding of the Woman's Medical College of Pennsylvania, and the alumnae of the institution are anticipating and planning for a fitting celebration of this epoch in the history of the education of women in medicine. Elaborate jubilee exercises are being arranged for this occasion, an interesting feature of which will be the presentation, at the next annual commencement, of a portrait of the late Dr. Ann Preston, who was a member of the first graduating class, and the first Dean of the Faculty. The winter session of the Woman's Medical College was inaugurated September 27th, the introductory address being delivered by Dr. Emma E. Munson, Professor of Laryngology.

The little circle of women, who about one year ago banded themselves together for the purpose of aiding the municipal authorities in promoting public health, has decided that in order to extend their field of usefulness it is advisable to become incorporated. Application to the courts for a charter has, therefore, been made, and henceforth the association will be known as "The Woman's Sanitary League of Pennsylvania." Many of the members have enjoyed wide experience as workers in other sanitary associations, and the first meeting of this new society, to be held during the coming week, will, it is confidently expected, inaugurate an important and busy winter session, to be characterized by increased activity, and by a largely extended scope of the society's labors.

At the meeting of the Philadelphia County Medical

Society, held September 13th, a committee of five members was appointed to confer with the Mayor on the subject of street blockades during the progress of parades, and to arrange to overcome the difficulty experienced by many physicians when on professional calls in getting through the lines of march. It is believed means will be devised by which physicians in future will be given the opportunity to pass through the lines.

The trustees of the Frederick Douglass Memorial Hospital have issued an appeal for funds, to be used in the erection of a larger and more modern hospital building, the expense of the new structure being estimated at about \$75,000. The Frederick Douglass Hospital was established four years ago by Dr. N. F. Mossell, the first colored graduate of the Medical School of the University of Pennsylvania, and has devoted its purposes especially to the training of colored women in the nursing profession. Owing to the limited facilities of the institution, last year but six student-nurses could be admitted, out of a total of fifty-eight applicants.

The corner-stone of the Lucien Moss Memorial Home, of the Jewish Hospital, was laid with appropriate ceremonies on September 22d. The new building is to be a part of the main hospital and its cost, including construction and endowment, will be in the neighborhood of \$200,000. It will be ready for the reception of patients next spring.

Dr. J. T. Rothrock has been reappointed State Commissioner of Forestry by Governor Stone. Dr. Rothrock was originally appointed to the position by Governor Pattison eight years ago, and so valuable has been his services that he has held the same office through three successive administrations.

At the last meeting of the Board of Charities and Correction held this week, the appointments of Drs. W. B. Jamison and T. W. Kirkbride, as assistant pathologists to the Philadelphia Hospital, were announced.

The number of deaths in Philadelphia during the week ending September 23d was 371, or an increase of 7 over those of last week, and a decrease of 5 from the corresponding week last year. The following returns of contagious diseases were made: Enteric fever, 76 new cases, 6 deaths; diphtheria, 67 new cases, 18 deaths; scarlet fever, 54 new cases, 3 deaths.

SOCIETY PROCEEDINGS.

THE INTERNATIONAL CONFERENCE FOR THE PREVENTION OF SYPHILIS AND VENEREAL DISEASE.

Held at Brussels, Belgium, September 4 to 8, 1899.

[From Our Special Correspondent.]

THIS meeting may be regarded as one of the most significant in which medical men have ever taken part, since it marks the first international official recognition of the dangers of venereal diseases to society at large. Not only was practically every civilized country represented among the delegates, but the leading parts in the Congress were assigned only to those legal experts and med-

ical specialists whose places at the very head of their respective professions are undisputed. Most of the Continental governments were represented, either directly by the cabinet minister in whose jurisdiction such social questions are placed, or by a personal substitute with equal authority. The *raison d'être* of this Congress lies in the fact that while the advances in medicine and sanitation have enormously reduced the proportionate mortality of many maladies, and in numerous instances have practically stamped out others, yet syphilis and gonorrhea have spread unchecked to every portion of the inhabited earth and into all classes of society, until today they constitute a greater and more actual menace to the health of the people than even cancer and tuberculosis.

The efforts of the Conference were not undertaken in the interests of those who lead an immoral life, but rather on behalf of the tens of thousands of innocent victims who, either through accidental infection or through the sins of husband, father, or brother, are forced to take up one of the heaviest crosses known to man, and bear it silently, often to the grave. It is only within the last few years that investigators have shown us the prominent part which syphilis plays in the etiology of the severest and most hopeless diseases of the nervous system and brain, and that gonorrhea is often in reality a general systemic infection, capable of causing in women inflammatory conditions of the uterus, ovaries, and peritonium for which no efficient remedial measure has yet been found, and in both sexes such grave conditions as meningitis and peri- and endocarditis.

Inasmuch as the main questions, "The Dangers of Syphilis to Society" and "The Dangers of Gonorrhea to Society" formed the most important subjects for discussion, and about which the remaining themes were grouped, so it devolved upon the two gentlemen selected to present these questions to assume charge of the larger share of the work of the Congress. These men stand so preeminently first as the highest authorities upon their respective branches that a word concerning their personalities may not be out of place.

M. LE PROFESSEUR HENRI FOURNIER, who spoke upon the menace of syphilis to society, is of all the men in the world the one best qualified to do so. As *chef de clinique* of the venereal division of the world-famous St. Louis Hospital in Paris his experience is enormous. His books, "Syphilis et l'Herédité," and "Syphilis et Mariage," as well as those from his facile pen dealing with the treatment of the disease, have long been regarded as classics; they have been translated into all of the modern languages.

PROFESSOR NEISSER, the discoverer of the gonococcus and originator of most of our modern methods of treating gonorrhea, is not only the highest authority upon this subject, but his brilliant research work in the domain of dermatology has won for him a place among the specialists in this branch second to none in the world. Though still comparatively young, Professor Neisser is the director of the newly erected Royal Dermatological Hospital at Breslau. He also enjoys the still greater honor

of being the founder of, and leader in, what is now known as the "Breslau School," the tenets of which aim to sweep away the empiricism which seems to cling so persistently to the pathology and therapeutics of skin and venereal diseases, and the placing of these subjects upon a rational, scientific basis.

Among the medical men who presented reports upon the other questions on the program, perhaps the best known is PROFESSOR DR. KAPOSI, whose text-book on skin diseases is probably the best in the German language. He is the physician in charge of the dermatological clinic of the Vienna General Hospital, the leading exponent of the ideas of his venerated master, Hebra, and the undisputed leader—one might say czar—of the Vienna specialists in diseases of the skin.

PROFESSOR DR. LESSER of Berlin University and the director of the cutaneous and venereal division of the Charité Hospital of that city probably numbers among his students more foreigners than any other instructor in the same subjects in Europe, and any one who has had the privilege of listening to his instructive lectures will not wonder at the reason for his popularity.

DR. BESNIER is *chef de clinique* of the dermatological part of the St. Louis Hospital, an exceedingly careful, thorough worker and clinician, the presiding officer at the meetings of several Parisian medical societies, and a splendid representative of French medical science.

PROFESSOR FINGER of the University of Vienna has written two excellent works upon venereal diseases, and is Austria's most progressive specialist in this branch of medicine. As a close and accurate student of the pathology of syphilitic and gonorrhreal processes Professor Finger is known throughout the world.

PROFESSOR LASSAR owns the largest and best-appointed private clinic in Berlin, and is the editor of the *Dermatologische Zeitschrift*, in which the results of his own work and that of his assistants are published.

PROFESSOR YADASSOHN of Berne⁴ has already published several interesting articles upon the subject of prostitution and its control by the State. He was for several years first assistant to Professor Neisser at Breslau, and is, like his celebrated teacher, an expert in pathological histology and bacteriology.

The delegates from England contain among their number several of the most distinguished medical authorities in the United Kingdom. DR. JONATHAN HUTCHINSON of London is undisputably the highest authority on syphilis and venereal diseases among English-speaking physicians, and in the estimation of all other nations is placed second only to his friend, M. Fournier. Dr. Hutchinson enjoys almost every honor which British medicine can give.

As a syphilologist DR. ALFRED COOPER has already won a high position for himself, and his ably written books on venereal disease are very widely read. DR. RADCLIFFE CROKER of London is not only a splendid representative of the British dermatological school and the ideal type of the English gentleman, but as a specialist and teacher of diseases of the skin he stands among the best in the world.

COLONEL RICHARDSON and MAJOR MACPHERSON are the official representatives of the English Army Medical Corps.

PROFESSOR SAUNDBY is president of the Council of the British Medical Association, and delegate of that Society at the conference.

DRS. DRYSDALE of London and BIRBECK-NEVINS of Liverpool, HENRY WILSON, M.P., and MISS LEPPINGTON of Warwickshire are the leading English members of the minority which opposes official recognition of prostitution.

America was represented by DR. LISTON MONTGOMERY of Chicago, delegate of the United States Government, American Medical Association, Chicago Medical Society, and Chicago Board of Health; DRs. LUSTGARTEN of New York, BLOOM and KASDIN of the United States Navy. Of these Dr. Montgomery alone took an active part in the proceedings.

The above list is far from complete, and many names, known wherever medicine is practised, must be omitted for lack of space. Before concluding these notes some mention must be made of the splendid representatives of Japan. This country sent to the Conference no less than five, who were certainly a credit to their native land. In their thorough comprehension of the questions discussed, their extraordinary command of the three languages used, and their highly finished manners they won immediate recognition.

The majority of the members of the Congress arrived during the Saturday and Sunday preceding the opening session, and on Sunday evening were brought together and handsomely entertained at the Hotel Ravenstein, where they were afforded a most welcome chance to become generally acquainted. On Monday evening the presiding officer, M. Lejeune, received the members at his beautiful residence. The evening of the following day was used by the Minister of Foreign Affairs, M. Favreau, and his charming wife, who gave a ball. The Mayor of Brussels and Councillors of the city threw open the famous Hotel de Ville on Wednesday from 9 to 12 P.M., and gave the participants in the Conference a chance to see the beautiful works of art which this wonderful and historic structure contains.

The banquet, given at the Grand Hotel, for the foreign members by those from Belgium and the Organization Committee, was a delightful and brilliant climax to the hearty, sincere, and most lavish hospitality which, from the beginning, had formed such a leading feature of the event, and contributed so greatly to general cooperation in the work.

But the delegates and members were, at the close of the final session, shown a still greater honor, as the King of Belgium, who had been following the proceedings from day to day with great interest, journeyed from his summer palace at Laeken in order to receive the participants at the royal residence from 3 to 5 P.M., and to thank them for their labors.

The organization of the meeting was simply superb. On every hand the members found their wishes anticipated and fulfilled, their requests attended to with cour-

teous alacrity and precision, and such kindly aid shown one and all that the confusion, which is almost an inevitable concomitant of all large gatherings, was entirely absent. Each detail was systematized so thoroughly that the business went through with beautiful smoothness. Indeed, the amount of care and intelligent forethought was such, that upon the spontaneous suggestion of a large number of members, a subscription list was quietly started and so well subscribed to, that on the following evening, at the beginning of the banquet at the Grand Hotel, an exquisitely executed bronze statue was presented to the secretary-general and leading spirit of the organization committee, DR. DUBOIS-HAVENITH, as a grateful tribute to his ceaseless and untiring labors, which did so much to make the Conference so successful.

The beautiful *salle de débats*, of the Palais des Académie, embellished with famous historical paintings, statuary, and busts, was tendered by the city for the use of the gathering, and the scene at the opening session, Monday morning, September 4th, was both brilliant and impressive. The gala uniforms of France, Germany, Austria, Russia, and Belgium, as well as the colored ribbons, medals, stars, and grand crosses of the chief European civil and military orders, were everywhere in evidence. In a few minutes the members had seated themselves. The Minister of Agriculture and Public Works, M. LE BARON LE BRUYN, M. LE DR. TROOZ, Minister of the Interior, and M. BULS, Mayor of Brussels welcomed the members of the Congress in most cordial speeches and expressed the heartiest sympathy with the objects of the meeting, together with the sincere hope that success might crown the efforts of the assemblage. Dr. Dubois-Havenith then announced the selection of the following presiding officers: President, M. le Sénateur le Jeune, Minister of State; Dr. Dubois-Havenith, secretary-general; Dr. Bayet, secretary. He then declared the meeting open, and the work of the day was at once begun.

The first question: "Does Official Control of Prostitution Lessen the Spread of Venereal Disease?" occupied both the morning and afternoon sessions of Monday and the entire session of Tuesday. Speeches were limited to a quarter of an hour, and in the first half-dozen discourses it became evident that while the majority of the members regarded municipal supervision of some sort as our only means of combating this terrible scourge yet the minority composed of DRs. AUGAGNIER of Lyons, A. FIAUX of Paris, and DRs. DRYSDALE, and NEVINS, MR. WILSON, M.P., and MISS LEPPINGTON of the English delegation, made up in aggressiveness what they lacked in numbers, and in vigorous speeches denounced as wholly bad every form of legal measures. The English members based their arguments upon the workings of their "Contagious Diseases Acts," which were abolished in 1886. They claimed that not only did these laws fail to improve the sexual health of the people, but the large increase of venereal disease may be directly attributed to such legislation. Here several members arose to question the thoroughness of execution of these laws. Drs. Augagnier and Fiaux based their opposition upon the many obvious defects of the present Parisian prostitution

regulations, and presented to the members many elaborate tables of figures which were supposed to show the futility of all governmental interference. These formidable weapons in the argument were soon rendered useless, however, by an extremely clever motion by DR. EHLERS of Copenhagen, who reminded the members of the many failings of even the most careful tables of statistics, and advised that all speakers should dispense as far as possible, with these. The suggestion met with immediate general approval, much to the disappointment of the minority. The English representatives of the opposition had covered many square yards of the walls with huge statistical charts, and had relied chiefly on these for the basis of their antagonism.

PROFESSOR FOURNIER of Paris spoke several times of the workings of the present regulations, and freely admitted their many shortcomings and incompleteness. He said that in spite of their many obvious defects, many of which could be remedied, these measures could not help doing a very great amount of good, for even though they enabled the segregation and compulsory treatment of only a half or a third of all syphilitic courtesans, yet this meant the isolation of so many centers of contagion. And inasmuch as each woman would otherwise infect from two to four men daily, as prophylactic measures the value of all such laws are beyond dispute.

PROFESSOR NEISSEr heartily endorsed all that his predecessor had said, and desired to express his entire confidence in the ability of suitable laws, properly executed, to diminish the amount of venereal disease. We succeed in preventing the spread of many contagious diseases by legal measures, and if those against the most dangerous of all foes of public health, venereal disease, were to be executed with an energy equal to that with which we fight some of the acute exanthemata, our results would be equally satisfactory. These is no reason why gonorrhea and syphilis cannot be enormously decreased, and in course of time almost stamped out. It is all a question of energy, determination, and concerted international action.

PROFESSORS KAPOSI of Vienna and LASSAR of Berlin believed thoroughly in the efficacy of official control. It is our only means of controlling existing evils and preventing their continued increase. Those who would abolish such control assume an attitude of unproductive cynicism, and are unable to suggest other practical remedial measures. The evil increases daily; something must be done for the sake of the health of future generations. Instead of disparaging all efforts toward lessening the spread of this disease, we should use our time and energies toward the perfecting of all means which are to day at our command. This is the only manner in which we can succeed.

MISS LEPPINGTON of Warwickshire, England, presented several aspects of the question under discussion, but as her discourse touched upon the moral rather than scientific side she was called to order by the president and obliged to desist.

DR. BIRBECK-NEVINS of Liverpool read what was perhaps the most representative paper of the opponents of

official regulation, but, like those of his countrymen, his arguments were based wholly upon the rather doubtful workings of the English prostitution laws, and hence did not make much impression. DR. NEVINS, after relating the results of all English measures on behalf of the Army and Navy, quoted statistics published some years ago by Professor Fournier. The latter gentleman, however, in a few words exposed the false interpretation to which his figures had been put, and DR. NEVINS retired.

The discussion of the first question continued throughout the first three sessions without any general and unanimous conclusions having been reached.

On Wednesday morning, the third day, work upon the second and third questions was begun. The theme, "Is the Present Organization of Medical Surveillance Capable of Improvement?" brought out many interesting suggestions. PROFESSOR YADASSOHN of Berne who, owing to the illness of PROFESSOR FINGER of Vienna was the sole official reporter, is already well known for his previously published works upon this subject. He made the following proposals: More frequent and more thorough medical examinations; syphilitics should be under control and treatment for their own sakes as well as that of the State for at least three years; first in the hospital until the infectious stage has passed, and then in the polyclinic (out-patient department). State control certainly does, to a certain extent, protect debauchery. It should, therefore, be generally known that even the best supervision can by no means guarantee against venereal infection; microscopic examinations of gonococci in all cases of suspected gonorrhea, and more thorough and longer continued treatment of this disease. DR. FIAUX (France) once more presented endless statistics to prove the harm which official control causes.

DR. LE PILEUR spoke of the practical workings of various systems of control applying to houses of ill-fame and *maisons d'assignation*, and expressed the opinion that such supervision should be arranged not only to offer far less offence to the public morals, but surely and absolutely to prevent the spreading of venereal disease. Indeed, it is in the houses that regulation could be carried out to perfection.

DR. HOEFFEL of Alsace-Lorraine, though a decided believer in official control, showed that such measures had been thoroughly carried out in Alsace, but for some reason unknown had proven useless.

DR. BLASCHKO of Berlin, author of several works upon the subject, took a position in the discussion between the advocates of official supervision and those who would abolish it. As a result of his large practical experience as an official of the sanitary police in Berlin he thinks the present systems in vogue are inappropriate because they apply only to the older prostitutes, and not to the more active, more dangerous, but less known younger ones. He proposed that only those prostitutes who are known to have caused venereal infection or are guilty of gross indecency should be placed under surveillance. In these instances compulsory laws are absolutely necessary.

M. RETHAN MACARE, Chief Justice to the Queen of

Holland, opposed control of bawdy houses, as he believed this would increase immorality.

DR. BLASCHKO again rose to say that treatment of venereal diseases should be largely voluntary. PROFESSOR LESSER of Berlin disagreed upon this point. He said that infected women do not feel inconvenienced or actually ill, and, therefore, would certainly not be likely to present themselves for treatment of their own accord, but would more probably go about spreading their disease. They should have adequate treatment forced upon them, as much for their own sake as for the sake of public hygiene.

PROFESSOR FOURNIER of Paris stood decidedly for regulation, especially of brothels, as the results of supervision are in this class especially promising, and could be made more so. To omit this would be casting away one of our strongest weapons. The state of the prostitutes themselves would be greatly bettered; they would be freed from their present slavery to the keepers of houses, and would always have a chance to reform. The stricter police surveillance would make such resorts less attractive to revellers and all classes of patrons. From a sanitary standpoint everybody admits the immense improvement which would result. Then why not adopt such control?

MADAME BIEBER-BOEHM of Berlin, President of the German Society for the Protection of Young Girls, read an extremely able and reasonable paper. She called upon physicians to make more use of their opportunities to give sound moral counsel to their youthful patients.

On the fourth day, September 7th, although work upon the fourth and fifth questions of the meeting was begun, the speeches differed but little in their ideas from those of the previous days. It became a hotly contested discussion for and against official recognition of prostitution, rather than of the details of the subject. Nor was this improper, since the definite endorsement of control of prostitution by the State would render all other remaining work a matter of detail, to be adapted to the conditions prevailing in each country and perfected by the results of practical experience. That a unanimous conclusion could be reached was hardly expected, even by the most sanguine of the gathering. So the results of the prolonged debate were far from disappointing, though they left the subject practically where it stood at the beginning. One could note the almost hourly increase of interest in the work, and many prominent men, whose presence had previously been chiefly of the perfunctory sort, toward the closing hours became impassioned speakers for the affirmative or negative side of the question. That from now on the subject will receive the closest attention, not only from the highest medical authorities, but from students of social science and the most influential of public men as well, can hardly be doubted. It is in arousing such genuine, widespread, and enthusiastic interest in the question of prostitution and prevention of venereal disease that the Conference achieved a far greater and higher aim than anything which could be represented in a few crystallized resolutions. Nevertheless, these were not wanting, for after HERR SCHMOLDER of Westphalia, DR. MIREUR of Marseilles, FIAUX,

PIERSON of Holland and several others of the abolitionist side had stated their views in fifteen-minute speeches, PROFESSOR FOURNIER arose and offered for endorsement by the Congress the following recommendation:

"The International Congress for the Prophylaxis of Syphilis and Venereal Diseases expresses the desire that the various governments use all powers with a view to suppressing absolutely prostitution amongst girls who are regarded according to civil law as minors." After one or two inquiries concerning the technicalities of translating this into English and German had been made, the recommendation—the authors of which are Professor Fournier and the Minister of State, Lejeune—was passed by a unanimous vote amid great applause.

The remaining time of the day's session was put to excellent use by M. GEORGES HONNORAT, Chief of the First Division of the Prefecture of Police, Paris, who explained the workings of the Parisian regulations regarding prostitutes and brothels. As a result of his wide experience he has become a firm believer in the efficacy of official control of such women.

On the fifth and last day, September 8th, the interest and enthusiasm, so noticeable on the previous day, reached its height, and together with the brilliant speeches of the leading men and the passing of important resolutions, combined to form a fitting close to the memorable gathering.

M. RETHAN MACARE, PROFESSOR WOLFF of Strasburg, PROFESSOR HOLST and DR. MORGENSTEIN of Christiania were among the first speakers. PROFESSOR NEISSEr then arose, and in a short but forceful speech expressed his views. To one who looks at the subject fairly and practically there is not the slightest ground for cynicism concerning the results of intelligent treatment of syphilis and gonorrhea. As one of especial experience in the treatment of the latter disease he wished to express in the strongest possible terms his disapproval of those who are therapeutic nihilists as far as these maladies are concerned. The prompt and energetic treatment of gonorrhea in its first stage is in nearly all cases followed by a thorough cure. The disease in the female, if we can attack it before it has passed beyond the cervix, will yield as readily as in the man. This is one of the strongest grounds for advocating official control of prostitution. Such control, if left chiefly in the hands of police officials, certainly would in many ways be open to well-founded objection. It should, therefore, be almost wholly medical in character, with police always at hand to enforce obedience.

DR. JONATHAN HUTCHINSON of London then arose amid great general enthusiasm, and his only speech at the Congress will certainly become a classic upon the topic. Dr. Hutchinson said that after studying syphilis and its manifestations as he sees it in England, he has become an optimist regarding the influence which the disease exerts upon the Anglo-Saxon race. He recognizes the extreme gravity of the malady, particularly in the etiology of the most fearful and hopeless affections of the brain and spinal cord, but deplores to the utmost the sensationalism which has caused such an exaggerated

fear of the disease. As regulation is an impossibility in England, we must perforce confine our efforts to suppressing as far as possible the transmission of the contagion. After an experience extending over fifty years, Dr. Hutchinson has reached the conclusion that when syphilis has existed in a patient for a period of two years it is then incapable of being transmitted hereditarily. The spread of the infection is thus, to a certain extent, limited by time. Hereditary syphilis is almost unknown in the better classes of society, and if the poor people—who suffer from it most—could enjoy the same facilities for treatment, they would be equally free from such forms of the disease. Syphilis which has been inherited does not extend to the third generation. Dr. Hutchinson heartily endorses early treatment, as when this is begun before the secondary symptoms appear, the most contagious period of the disease is entirely suppressed, and the danger of contagion accordingly diminished. This method is now so generally used in England that in private practice a well-marked case of secondary manifestations is comparatively rare. The hospitals should readily and willingly admit all cases of syphilis without question and give thorough treatment for the disease.

All places where young men congregate should be made to furnish instruction upon the dangers of prostitution and the venereal diseases. Moral education, without reference to religion, should endeavor to foster higher respect for women. This, now more prevalent than in former years, Dr. Hutchinson has noticed particularly among his medical students. The sense of responsibility in sexual matters should be increased. The Quakers believe in the laudable idea of masculine chastity until marriage, and to this the speaker attributed the total freedom of this sect from general paralysis of the insane. In regard to the Army and Navy, the old notion that drunkenness and debauchery is only to be expected of the common soldier and sailor should be done away with. We should make him respect himself, and in turn respect him as we do any decent workingman.

There should be better post-graduate medical education in order to enable all practitioners to receive the instruction and experience necessary for the accurate diagnosis and proper treatment of venereal disease. Under the systems of teaching now in vogue this, the right of every patient, could hardly be expected of the young medical graduate.

As a result of his individual knowledge of the extent of syphilis prevailing in the English Army, Dr. Hutchinson believes that the reports of its influence upon, and frequency among, the men has been greatly exaggerated, and the official reports upon the subject falsely interpreted. He is strongly opposed to the State taking under its protection such a vice as prostitution, but is sure that the people of Great Britain would gladly endorse all other means, which will probably be of a moral character.

PROFESSOR LESSER of Berlin did not agree with Dr. Blaschko regarding voluntary treatment of venereal disease. That is, that treatment of venereal disease should be made optional, not compulsory, in the out-patient department of hospitals, as the class who are seen here live

in dwellings which from a hygienic standpoint are miserable, and have neither means nor facilities for obtaining nourishing food and bathing which to-day play such an important part in our modern methods of treatment of severe venereal cases.

PROFESSOR FROISFONTAINE of Liege showed the Congress copies of the little books of advice and warning of the contagious nature of the maladies and necessity for their cooperation for thorough treatment, etc., which are supplied to the venereal patients of the Royal University Dermatological Hospital of Breslau. Professor Froisfontaine heartily endorses this simple but effective means of diffusing knowledge of the contagiousness of syphilis and gonorrhea among lower circles.

PROFESSOR FOURNIER of Paris suggested that the best prophylaxis against the spread of venereal disease is the more thorough treatment of that already existing. This is especially so regarding syphilis. If necessary the expenses for thorough treatment of each case should be borne by the government. It should supply ample free treatment for all specific cases applying for such. In each patient the cost to the government of all medicines would not be more than a dollar, and for this sum the treatment would in all cases certainly tide over the most infectious stage, and in many result in a permanent cure. The speaker, therefore, offered the following suggestions: (1) Absolutely free treatment for all cases of syphilis. (2) The facilities for the most thorough treatment of all cases of syphilis should be improved and extended. (3) The privacy of the consultation of a free venereal patient with the hospital physician should be equal to that prevailing in private practice, and measures ought to obtain this result. It should be made a rule that each patient's talk with the physician should be behind closed doors and alone with him. The methods now existing in many hospitals amount almost to a "public confession" of syphilitic infection. This not only injures the patient's social prospects, but his material ones as well.

The speaking at the Congress was now at an end, and the following recommendations, which had been carefully prepared by the members during the previous two days, were then unanimously adopted.

I. The resolution of PROFESSOR FOURNIER, as already stated, concerning international measures for the abolition of prostitution among females of minor age.

II. That the present conference serve as a beginning for the foundation of an International Society for Moral and Sanitary Prophylaxis against the Evils of Prostitution and Venereal Disease. That such Society shall publish a quarterly report or magazine containing articles by the members upon these social questions. That the next reunion of the Conference will be held in 1907 at Brussels and every three years thereafter. That the official seat of the permanent committee shall be at Brussels. That French shall be the official language, but articles in French, German, English, and Italian may be accepted for publication. The following provisional committee on organization was elected: President, M. LEJEUNE, Minister of State, Brussels; vice-president, M. BECO, Minister of Public Health and Hygiene; secretary-gen-

eral, M. DUBOIS-HAVENITH, agrégé de l'Université de Bruxelles.

III. Resolution presented by PROFESSORS FOURNIER, NEISSER, HUTCHINSON, LESSER, WOLFF, and MRACEK: The Conference holds that a thorough knowledge of venereal disease constitutes one of the most important means of combating the spread of these maladies. The governments are therefore urged to compel the most thorough education of students in this branch. That the instruction should in all cases be given by competent specialists, and there should be instituted in each university complete and obligatory courses upon these diseases. That each government should insist upon a strict examination in these subjects, to be presided over by specialists, as requirement for the medical degree.

IV. That the guardians of orphans be held responsible to the State for the moral welfare as well as the material interests of their charges. That those entrusted with the education of youths will give all possible solicitude to their moral development, which is to include the common-sense principles of temperance, and the cultivation of a high, manly respect for woman, whatever be her social condition.

V. The Conference pleads that the governments use the greatest possible severity in punishing panderers and procurers.

VI. Proposed by PROFESSOR SAUNDBY on behalf of the British Medical Association: The Conference demands of the governments of all countries the establishment of a commission whose duty shall be: (1) To determine the frequency of venereal diseases amongst the civil population exclusive of temporary variations. (2) To inquire into the institutions already in existence for the treatment of venereal disease, the distribution of such hospitals, the number of beds at the disposal of each locality, and the proposal of the most effective measures for treatment of these maladies. (3) The collection of different opinions concerning the best means for preventing and effacing the dissemination of venereal disease among the civil population, and reporting their conclusions.

VII. Proposed by PROFESSOR LASSAR of Berlin: The governments are urged upon all favorable occasions to call the attention of the population, and particularly the young men, to the dangers of prostitution to both sexes and the sinister consequences of venereal disease.

VIII. Proposed by DRs. PIERSON and FIAUX: The Conference recommends that a uniform system shall be used in all countries for the gathering of statistics concerning prostitution and venereal disease.

PROFESSOR FOURNIER rose at the end of the session and proposed that the members of the Conference offer a vote of thanks to the Belgian government for its splendid hospitality and kindness to the Congress, also that an expression of gratitude be extended to the organizer of the Congress, Dr. Dubois-Havenith, and his able assistants, for their untiring and constant efforts which had contributed so largely to its success as well as the pleasure and comfort of the members. This resolution was passed amid great applause, and the Conference ended.

CHARLES WOOD MCMURTRY, MD.

BRUSSELS, September 9, 1899.

AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

Abstract of the Proceedings of the Twelfth Annual Meeting, Held at Indianapolis, Indiana, September 19, 20, and 21, 1899.

FIRST DAY—SEPTEMBER 19TH.

THE Association convened in the Century Club rooms of the Denison House under the Presidency of DR. EDWARD J. ILL of Newark, N. J. An address of welcome was delivered by Mayor Taggart, which was responded to by the President. After the transaction of routine business in executive session the reading of papers was proceeded with.

DR. JAMES F. BALDWIN of Columbus, Ohio, reported

THREE RARE CASES OF KIDNEY CYSTS.

CASE I. *Enormous Hydronephrosis Simulating Ovarian Cystoma.*—The tumor in this case filled the entire abdomen and entered the true pelvis, pushing the uterus to the left. The patient was unaware of the existence of any tumor, but thought she was getting stout for two years. There was no history whatever of any disturbance about the kidney. The enlargement was much more marked on the left side of the abdomen. At the operation the tumor was found to be hydronephrotic, of the right side, and with the entire destruction of all kidney tissue. The blood-vessels had so far disappeared that the only pedicle was an enormously distended ureter resembling a piece of small intestine. The cyst, which was retrocolic, was enucleated without special difficulty, and recovery was uninterrupted.

CASE II.—A large paranephritic cyst, containing about $1\frac{1}{2}$ pints of straw-colored fluid resembling urine. The cyst wall was exceedingly thin, but was successfully enucleated and the cavity closed with temporary drainage. Healing occurred by first intention.

CASE III. *Hydronephrosis of a Retrorectal Congenitally Misplaced and Sarcomatous Kidney.*—This tumor filled the pelvis, pushing the uterus up and pressing so firmly upon the urethra as to necessitate the use of a catheter. The rectum was so pressed upon as to render defecation almost impossible. After separating the tissues the cyst was tapped through the vagina and about one quart of urinous fluid drawn off. The completion of the enucleation had to be made through the abdomen. The specimen proved to be a sarcomatous kidney congenitally misplaced in the pelvis. During the development of the disease hydronephrosis resulted, giving rise to the cyst which obstructed the pelvis. The patient recovered without difficulty and continued well at the time of the report.

While hydronephrosis simulating ovarian cystoma is not excessively rare, paranephritic cysts of any considerable size at least have been very seldom reported. The case of hydronephrosis of a pelvic kidney is, so far as the reporter could ascertain after a somewhat extended correspondence, entirely unique.

DR. JAMES F. W. ROSS of Toronto called attention to a point in connection with the diagnosis of cystic tumors of the kidney, and it was this: Given a tumor that

is unilocular by fluctuation, but looks like a multilocular tumor, in consequence of the striae it is always a tumor of the kidney, and not of the ovary. He believes that if the end of the ureter is tied with catgut it can be left in the course of a nephrectomy, and he does not think it is necessary to follow the ureter down to the bladder.

DR. LEWIS S. MCMURTRY of Louisville concurred in the remarks of Dr. Ross in regard to dealing with the ureter. In a number of cases of nephrectomy that he had performed the ureter was not dilated as much as in the case described by the essayist. In one case particularly he did not attempt to trace the ureter down to the bladder and remove it, but left it and it did not give any trouble.

DR. L. H. DUNNING of Indianapolis directed attention to an important diagnostic point in dealing with cysts of the kidney, namely, the presence of the colon in front of the tumor. He has been able to demonstrate this in large sarcomatous tumors of the kidney, and by pumping the colon full of air the distended colon can be seen running over the outer border or center of the tumor. He has removed three kidneys for tuberculosis. In one instance he did not tie the ureter; he did not dissect and remove it far down toward the bladder, and he had considerable trouble in that case, following it for some time. He thinks it is unsafe in tuberculosis of the kidney to leave the ureter and believes it ought to be removed low down in the pelvis and tied wherever it is left.

DR. J. HENRY CARSTENS of Detroit said that surgeons always had more or less difficulty in making the diagnosis in the cases under discussion, and while the point brought out by Dr. Dunning was a good one, it did not always hold good. He recalled one case in which he supposed he had an ovarian tumor, but found a hydronephrotic kidney as large as that of the first case reported by the essayist. The kidney was very loose and afterward a stone was found in it. The stone was quite large. He believes that when we have a loose kidney which flops around it may grow over the colon, and the colon in some of these cases is behind instead of in front of the tumor.

DR. JOSEPH EASTMAN of Indianapolis (by invitation), stated that he had recently had a case of pancreatic cyst as large as a human head or larger, and it was very satisfactory to notice the ascent and descent of this tumor during inspiration and expiration, a thing not possible if the tumor had been post-peritoneal or connected with the kidney. The pancreatic cyst had distended the mesocolon to such an extent that the transverse colon was very perceptible, lying across in front of the enormous pancreatic cyst; so that the diagnostic point mentioned by Dr. Dunning is applicable to pancreatic cysts.

DR. JOHN M. DUFF of Pittsburg narrated an instructive case in which a diagnosis of abscess of the spleen had been made, but a more careful subsequent examination revealed the fact that the tumor was connected with the kidney, as he had suspected. A median incision was made; the tumor had pushed up the mesocolon; the colon was adherent to the tumor around at the side, and the mesocolon was almost ulcerated through. The kidney was removed through the mesocolon. There was no secretion of urine from the kidney; an examination not

having been made with the Harris instrument for the purpose of ascertaining the condition of the urine from both kidneys.

DR. DUNNING asked as to the reliability of the Harris instrument, to which DR. BALDWIN replied that it was a very satisfactory instrument. He had used it several times in the female.

ECTOPIC GESTATION: SHALL THE PATIENT BE OPERATED UPON AT OR NEAR FULL TERM, THE CHILD BEING ALIVE?

DR. L. H. DUNNING of Indianapolis read a paper on this subject. As preliminary to a discussion of this theme, he reported the history of a case of ectopic gestation of eight-months' duration and operated upon five weeks after the death of the fetus. He said that the proper treatment of ectopic pregnancy after the six month, when the child is still living, is still under discussion. He wrote his paper for the purpose of considering one phase only of the subject, namely, shall operative intervention be instituted during the period of viability of the child, or shall we await the death of the child and the cessation of the active circulation of the placenta, then operate? The settlement of this question he said must hinge upon the relative mortality to the mother of the different procedures. The ectopic infant is of such low vitality and so frequently deformed that if to rescue it greatly jeopardizes the life of the mother, then ethically one must withhold the hand and permit it to die that the greater life may be saved. Such have been the sentiments of the writer for many years. He has had three cases of ectopic gestation at or near full term. In the first, the operation was done during spurious labor at full term. In this case, although fetal movements were detected one hour before operation, the child never breathed after removal by abdominal incision. The mother died the eighth day after operation of hemorrhage, resulting from the removal of the placenta which was left at the time of the initial operation. The placenta was removed thus early in consequence of impending death from septicemia. The other two cases were briefly narrated. A statistical table accompanied the paper. He stated that if the tables given by him approximately show the percentage of recoveries to mothers, then there was an answer to the perplexing and hitherto mooted question, "Shall operative intervention be instituted during the life of the child or only after its death?" We are not compelled to longer consider and weigh the probability of the length of life in days of the child; the safety of the mother alone demands intervention. Undoubtedly other questions will urge themselves upon us, such, for instance, as, Is it less dangerous to operate at six months or nine months? and, What treatment of the placenta yields the least mortality? These are still under discussion. "Is it safer for the mother to be operated upon in a case of ectopic gestation during the viability of the fetus?" The speaker said that in his opinion the statistics collected and compiled by him are so nearly complete and correct that the answer may now be given unqualifiedly in the affirmative. There will be undoubtedly individual cases in which the good judgment of

the surgeon will direct him to await the death of the fetus. These will be exceptional cases. The rule will be to operate at or near term during the life of the child.

DR. CARSTENS agreed with the essayist that the proper way, other things being equal, is to operate at once when the child is living and viable. The placenta is not always attached to the broad ligament. Often rupture takes place, and the placenta is attached to the intestine, the colon, the rectum, or the sigmoid, and in cases of that kind it is utterly impossible to remove the placenta when an operation is performed when the child is alive. He had seen such operations performed by other surgeons, and the patients invariably died from hemorrhage.

DR. MCMURTRY thought Dr. Carstens struck the keynote in determining the course to pursue in these cases. By referring to one of the earlier volumes of Transactions of the Association a case reported by him would be found where the fetus had gone to full term, was dead, and some weeks after a spurious labor, when there were beginning septic symptoms, he operated. No fetal movements had been observed for nearly three weeks. The placenta was very large; there was no sign of any atrophic changes in it in consequence of the death of the fetus; it was spread out over one side of the uterus, over the colon and ileum, and there was such a hemorrhage as will obtain from an attempt to enucleate the placenta as never will be seen under any other circumstances at the operating-table. It was perfectly dreadful, the woman being exsanguinated within a minute, the pelvis being full of blood. When the placenta is disposed toward the broad ligament and uterus, as in the case described by Dr. Dunning, he believes there is a good opportunity for complete enucleation of it.

WHAT SHALL WE DO WITH THE POST-OPERATIVE HEMORRHAGE OF CELOTOMY?

This was the title of a paper contributed by DR. D. TOD GILLIAM of Columbus, Ohio.

Cases of post-operative hemorrhage were cited. The author said he had very little to offer in the way of suggestion. Some time since he had in charge a young lady who was subject to the most violent and persistent uterine hemorrhage of unaccountable origin. She had passed through many hands before coming to him, and he had tried many of the vaunted remedies without avail, as she could not make up her mind to have a curettage, and during one of her spells she fell into the hands of his brother, DR. CHARLES F. GILLIAM. He placed her on atropin with the result that after the physiological effects of the drug became manifest the bleeding ceased. Since then her attacks have been less frequent and always promptly amenable to the atropin treatment. Other cases followed in the practice of Dr. Gilliam and his brother, among which were some in which the patients had been curedtted, and in every instance so far the hemorrhage had been controlled by the atropin. The results had been so convincing in these cases that had fallen under his observation as to force conviction.

As to the modus operandi of atropin he could only speculate. It is known that atropin increases the cutane-

ous circulation, producing a general and marked hyperemia of the surface; it is known that the cutaneous vessels are capable of containing nearly one-half of the blood of the body, hence by derivation it diminishes the amount of blood circulating in the internal organs. The author thinks it quite likely that the vasomotor action which dilates the cutaneous vessels coincidentally and by way of equation constricts the visceral vessels. The duodenal ulcers resulting from extensive burns of the skin would argue in favor of compensatory vascularity. It is not expected that this or any other medicinal agent will arrest the torrential hemorrhage of the larger vessels, such as the uterine or ovarian arteries, but is especially applicable to that troublesome form of hemorrhage which emanates from numerous vessels of smaller caliber.

DR. H. W. LONGYEAR of Detroit said that there is no class of cases more puzzling to him than those which showed the condition of collapse described by the essayist, indicative of internal hemorrhage. And yet there are other conditions which produce the same symptoms, and the surgeon has got to use fine discrimination. If he knows a vessel is bleeding, he considers it his duty to cut down and search for the bleeding-point, no matter what the condition of the patient may be. In a case of ruptured tubal pregnancy, where there is internal hemorrhage going on, it is the duty of the surgeon to reopen and do the best he can. It is not always easy to find the bleeding vessel.

DR. RUFUS B. HALL of Cincinnati stated that hemorrhage or shock could be determined largely by the operator himself. When a patient is put to bed after an operation the surgeon is pretty well aware whether there is great danger of secondary hemorrhage or not. If the operation has been a complicated one and a condition is left which adds to the risk of hemorrhage, this aids the surgeon materially in determining whether or not the patient is bleeding or suffering from shock. He would not hesitate a moment to take out a stitch, after the abdomen is closed without drainage, and he believes without very extensive exploration he could determine readily and certainly whether hemorrhage was taking place or not.

DR. EDWIN RICKETTS of Cincinnati said that whenever ligatures are used there is one procedure that is very valuable, one always resorted to by Bantock, that is, crushing the tissues for one-half or one-quarter of a minute by the heavy clamp, and after the removal of the clamp the ligature is applied. The angiotribe, which is being advocated by some operators, in which the ligature is not used at all, is applied and permitted to remain for two and a half minutes, and then removed, and it is claimed no hemorrhage follows its application. The plan, however, suggested by Bantock is one that should not be lost sight of in applying the ligature.

DR. ROBERT T. MORRIS of New York made some remarks on

COCCYGEAL DERMOID FISTULE.

The subject of coccygeal dermoid fistulae is apparently one that has not received very much attention as he finds little reference to it in the literature. Occasionally some one has reported the finding of a dermoid cyst in the coccygeal

region, but without making comments on the way in which such cysts are likely to have been formed. He has seen reference to cysts only, but on making a study of the subject he finds that surgeons are much more apt to find fistulae than cysts. They are more apt to find depressions than fistulae. In the region of the coccyx not infrequently funnel-shaped depressions of the skin are found. Fistulae are less frequent, extending to a depth of from half an inch to four inches in his deepest case; and still less frequently wholly encapsulated cysts are observed. The fistulae and cysts contain straight hairs of the lanugo type mostly, although he has seen some nearly three inches in length, straight, in a mass, and welded together by sebaceous material. The sebaceous material escapes in large quantities from the fistulae; it remains encapsulated in the cysts and in the funnel-shaped depressions; it frequently dries upon the surface and comes away in the form of scales mixed with epidermis. When his attention was directed to the subject about a year ago he was surprised at finding the proportion of cases in which he noticed these funnel-shaped depressions or fistulae, or cysts of the coccygeal region, or dermoid cysts. It evidently represents an embryonal defect, and what this defect is he left the Fellows of the Association to suggest. There is a possibility that the tail of the embryo in undergoing involution leaves a portion of the skin highly endowed with embryonal latent cells, and that the skin developing more perfectly in the connective tissues about it, encapsulates, in part or in whole, this absorbing or involuting embryonal tail, so that in a coccygeal fistula we have an inverted tail. He has had four cases of coccygeal fistulae containing masses of hairs in his practice up to the present time.

In trying to remove them the surgeon must remove the entire cyst-wall or fistula wall, because it consists so largely of embryonal tissue that recurrence takes place promptly following the operation unless this is done. The method of treatment with nitrate of silver and with caustics results only in temporary destruction of the inner layer, just as when surgeons try to destroy bronchial cysts or bronchial fistulae, consequently recurrence takes place very promptly from the deeper layers of embryonal cells, the latent cells forming the structure again, so that they must be removed entirely. The author cited a case in point and exhibited microscopic slides.

HOUSE TO HOUSE OPERATING.

DR. EDWIN RICKETTS of Cincinnati read this paper. The skilled abdominal and gynecological surgeon of today is a product of surgical evolution, to which no man ever gave such an impetus as the great and lamented Mr. Lawson Tait. From him we have learned that the best results depend upon simplicity, thoroughness, rapidity, and rigid cleanliness; that his best work was done in house to house operating.

The advantages are many, and, briefly, are as follows: (1) The greater ability of the general practitioner to attend to the after-treatment, assisted by a competent nurse, the telegraph, and telephone. (2) The absence

of the mental dread of the patient to go into an institution, and the risk therein entailed, a condition by no means to be underestimated. (3) Iron bedsteads and improved household furniture are rapidly finding their way into country homes. (4) God's pure air, and undeniably less liability to infection.

DR. WALTER B. DORSETT of St. Louis said that the word simplicity in surgical work carries with it a great weight. The greatest men are known by their simple way of expressing themselves; and the greatest surgeons are known by their simple way of operating. There are many points that should not be overlooked in regard to the advisability of isolating patients from house to house. In the first place, the surgeon could not maintain the same discipline in a private house that he does in a hospital, whether there be a trained nurse or not, because the friends and relatives of patients are constantly coming in, they carry with them bacteria, and they have a certain amount of influence over the patient. The nervous system of the patient is more or less disturbed, and the recovery in a great measure is retarded. In hospitals a great many things are done that should not be done. Cleansing the hands by different methods is entirely unnecessary; green soap and plenty of it and good hot water are all that is necessary.

DR. J. HENRY CARSTENS regretted that the paper had been read, because he believes that its teachings are wrong and vicious. A great many general practitioners after reading the paper would laugh at aseptic surgery, as well as antiseptic surgery, and they would say there is no use in trying to practise it. When it comes to operating patients do far better in a hospital than at their private homes. A cervix operation or a perineal operation might be done at a private home, but when it comes to doing major operations it is far better to have patients in a hospital, where the surgeon has all the facilities for operating, etc.

DR. WILLIAM H. HUMISTON thought if Dr. Ricketts was taken seriously it would be a backward step of fifteen years. He could not believe that the essayist was serious in all the points he had made. Any one who has seen Tait operate knows that he was the perfection of cleanliness. Bantock was likewise one of the cleanest operators.

DR. WILLIS G. MACDONALD of Albany said that if our present system of operative surgery is correct, if it is based upon the destruction, or better, the evidence of micro-organisms, then the most painstaking technic which can be devised should be followed. He must not dispute the fact that the essayist could operate in almost any private house, but there was no likelihood of his having sterilized water to use about his patient, or about his hands, in any part of the building. In the State of New York people are beginning to appreciate what a good hospital really means; they appreciate what a good training-school for nurses means; they appreciate that they can be made much more comfortable and the chances of recovery are immeasurably increased by going to hospitals instead of remaining at their homes to be operated on.

DR. ROBERT T. MORRIS said the matter had to be

settled by statistics after all. The only statistics which he had in mind, were that he had lost eleven appendicitis patients; two of these died in hospital, and nine in house operations. The operations done in hospitals are certainly more than five times as many as those done at private homes.

PRIMARY SCLEROSIS OF THE OVARY.

A paper on this subject was read by DR. WILLIAM H. HUMISTON of Cleveland, Ohio. He said there are two distinct pathological conditions now classed as sclerosis of the ovaries, and universally believed to be due to inflammatory changes. There is a primary or non-inflammatory sclerosis, and a secondary or inflammatory fibrosis. These forms can be recognized both clinically and by microscopic examination. In the secondary degenerations is found (in a section taken from some portion of the ovary) a small, round-celled infiltration, or the connective-tissue elements in some of their various stages of development. Also, however advanced the stage of fibrosis may be, the numerical relation of nuclear to cellular elements in this variety is always greater than in the primary form. Thirdly, the microscopic appearances of the vascular system are also different. In the inflammatory group there is primarily a dilatation of the vessels with secondary contractions of their greatly thickened walls and a lessening of their lumen. In the primary group there is usually no thickening of the vessel walls; there is never any dilatation, and contraction occurs so early that one immediately notes the poor blood-supply, particularly to the periphery of the organ. In those cases of arteriosclerosis of the vessels, within the broad ligament is usually found the condition extending to the vessels entering the ovary, not otherwise. Lastly, in the primary group the epithelial cells of the ovarian stroma are diminished in number and usually in size. In some sections they are hard to distinguish from the connective-tissue elements, and appear to be undergoing a process of reversion. These several microscopic differences are constant and decidedly marked.

The diagnosis should be based upon the result of palpation of the diseased organs. The cirrhotic ovary is smaller than the normal, is hard and inelastic, and usually deeply corrugated. A sclerocystic ovary is usually larger than the normal organ, and is distinctly globular rather than ovoid. The tunica albuginea is always greatly thickened and is firm and unyielding. The size of the organ is due to the enlarged follicles just beneath the tunica. The hilum first shows the corrugations.

The condition is non-inflammatory and without a history of infection and without signs of peritonitis. It occurs in early life, from puberty to thirty, with dysmenorrhea often since the first catamenia. Amenorrhea or delayed menstrual flow and intermenstrual dysmenorrheic pain, described by every patient as being alike in character and severity with the pains experienced during each catamenia, are constant. This latter symptom differentiates the origin of the dysmenorrhea, making it clearly ovarian rather than uterine in its causation, and in itself is of chief importance clinically.

DR. F. BLUME of Pittsburg, Pa., read a paper, entitled "INTESTINAL ADHESIONS IN SUPPURATIVE PELVIC DISEASE; THEIR SIGNIFICANCE AFTER VAGINAL HYSTEROSALPINGO-OOPHORECTOMY."

The author stated that the time has passed when a surgeon can say without jeopardizing his reputation that he operates exclusively by the abdominal or the vaginal route. Since the introduction of vaginal hysterectomy and the revival of vaginal incision and drainage, our views regarding the treatment of suppurative pelvic diseases have undergone remarkable modifications. We realize that there is no longer but one method of surgical treatment and that, in order to do justice to the patient, we must select that method best adapted to the case. He has seen many women, who, after abdominal section for pelvic suppuration, performed in this country and abroad, were invalids, and he has performed a secondary operation upon a number of them. He has not, however, been called upon to treat a woman upon whom vaginal hysterectomy was performed by another surgeon, nor has any of his patients required or sought treatment at the hands of other operators. His experience is in accordance with the observations of other writers and justifies the assertion that the results of vaginal hysterosalpingo-oophorectomy in suppurative pelvic disease are excellent, notwithstanding the supra-pelvic complications, and there is no class of cases which, as a whole, gives more satisfaction.

(To Be Continued.)

REVIEWS.

NERVOUS AND MENTAL DISEASES. By ARCHIBALD CHURCH, M.D., Professor of Neurology in the Northwestern University Medical School and in the Chicago Polyclinic, etc.; and FREDERICK PETERSON, M. D., Professor of Mental Diseases in the Woman's Medical College, New York. Illustrated. Philadelphia: W. B. Saunders, 1899.

IN spite of its bulky appearance, this work is not a wide departure from the general run of text-books. Indeed, we cannot but condemn the tendency of publishers to sacrifice the convenience of handling for impressiveness of form. If we accept this sacrifice, however, we must admit that this book is a very handsome publication. Excellence of typography, neatness of arrangement and judicious use of italicized words all bespeak praise. To these have been added a profusion of illustrations, which is the chief characteristic of the work, as a book. These illustrations, mostly photographic reproductions, were chosen with admirable judgment, for they are highly descriptive in themselves.

The work is in two distinct parts by separate authors. The division on nervous diseases, written by Dr. Church, occupies the greater portion. While it has been condensed into text-book form, it is, in its way, very thorough. Each chapter shows a careful study of recent literature and the latest pathological data are everywhere included. In the chapter on leptomeningitis and in the

excellent, but brief, chapter on sinus-thrombosis, a more extended reference to bacteriological studies would have been a valuable improvement, even in a work of this character. On treatment, also, the text is quite up-to-date, as may be seen in the chapters on infectious and on paralytic forms of nervous disease.

With the exception of the very insufficient paragraph on erythromelalgia, the discussions of the more uncommon affections is ampler than in most text-books. They are nevertheless condensed. On the whole, Dr. Church's work exhibits an amplitude of detail and an accuracy of clinical description that will make it useful to a large number of practitioners, though it is rather too elaborate for students and not elaborate enough for neurologists.

Dr. Peterson's division on mental diseases, is also freely illustrated from very excellent photographs. In the chapter on the general etiology of insanity is reprinted, with a few changes, the author's article on "The Stigmata of Degeneration," from the *State Hospital Bulletin* of July, 1896.

Dr. Peterson's work is interesting in style but it presents no unusual feature and, indeed, hardly does him full credit. In the chapters on the special forms of insanity the following subdivision is employed: Mania, Melancholia, Circular Insanity, Epileptic Insanity, Dementia (primary and secondary); General Paresis, Paranoia, Idiocy, Imbecility, and Feeble-Mindedness. The usefulness of this classification is attested by its adaptability (with very slight amplification) to the needs of the New York State Hospitals for the Insane. The simplicity and elementary character of such an arrangement, however, at once precludes the work from usefulness to the alienist (for whom, be it said, Dr. Peterson did not profess to write it). Similarly the excellent chapter on idiocy deals for the most part with general considerations, the forms of idiocy being dismissed with scarcely more than their mere mention.

THERAPEUTIC HINTS.

For Uricacemia.—

B	Lithii citratis	gr. viii
	Ac. citri	gr. iss
	Oleosacchar. citrici	gr. iv.
M.	To make one compressed pastille. Sig. One dissolved in water three times a day.— <i>Peters.</i>	

For Periodic Neuralgia.—

B	Quininæ valerianat.	gr. xlvi
	Extr. juniperi	q. s.

M.	Ft. pil. No. XXX. Sig. Five to ten pills a day.— <i>Bouchardat.</i>	
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A Diaphoretic Powder.—

B	Pulv. camphor.	gr. iss
	Pulv. opii	gr. ss
	Potassii nitrat.	gr. v
	Sacchar. alb.	3 ii.

M.	Ft. pulv. Sig. To be taken in a hot drink at bed-time.— <i>v. Graefe.</i>	
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